WOMEN'S CHILDBIRTH EXPERIENCES IN TWO PUBLIC HOSPITALS IN LESOTHO

By

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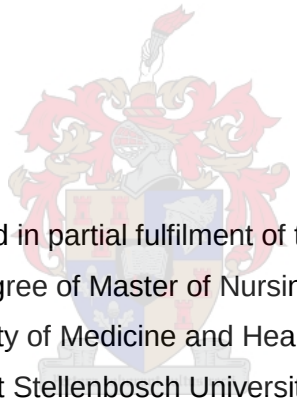

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DECLARATION

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ABSTRACT

Maternal death remains a threat to lives of women of childbearing age across the globe especially in low income countries. High maternal mortality is linked to poor quality care mostly around childbirth period. Quality care provision focus on two dimensions: provision of quality care by health care workers and experience of care by women. The study explored how women experienced care during childbirth.

The aim of the study was to explore women's childbirth experiences in two public hospitals in Lesotho so that services can be improved.

The research objectives were;

- To identify childbirth practices that can influence women's experience about childbirth.
- To describe women's experiences in relation to support given during childbirth
- To identify women's experiences about healthcare provider attitude during their childbirth
- To identify if women's childbirth needs were met.

A qualitative descriptive approach was applied to explore women's childbirth experiences in two public hospitals. The population was women who visited the post-natal clinic at 6 week after delivery in the participating hospitals. A purposive sampling was used to select 12 women who consented to take part in the study.

Data was collected through a semi structured interview guide and 3 participants were interviewed per day. Lincoln and Cuba's criteria of credibility, transferability, confirmability and dependability were used to maintain trustworthiness (Polit & Beck, 2012:560). .

Data was analysed through six phases of thematic analysis as described by Braun and Clarke, (2012:57). Six themes emerged: women's experiences about childbirth practices and services, support, provider attitude and communication, women's' needs for care, women's involvement in care and maternity ward environment and human resource.

The study findings revealed poor support during childbirth as midwives have other duties and companionship is not allowed in public hospital. The women's needs for care were not met: delayed care, shortage of staff and lack of involvement in care. The hospital environment was described as not conducive for women and their new-borns.

Conclusion: Shortage of midwives contributed to poor quality of care and lead to negative experiences. There is a need to strengthen the support structure during childbirth where infrastructural contracts and women's flow allows.

Key words: childbirth experiences, women's labour experiences, quality of maternal health care

OPSOMMING

Moederlike sterftes is ’n groot lewensbedreiging vir vroue van vrugbare ouderdom reg oor die wêreld, veral in lande met ’n lae inkomste. ’n Hoë moederlike sterftekoers is direk verwant aan lae gehaltesorg tydens bevalling. Gehaltesorgvoorsiening fokus op twee dele: gehaltesorgvoorsorg deur gesondheidsversorgers en vroue se ervaring van sorg tydens bevalling. Die studie ondersoek vroue se ervaring tydens bevalling.

Die doel van die studie is om vroue se bevallingservaringe in staatshospitale in Lesotho te bestudeer sodat die dienslewering verbeter kan word.

Navorsingsdoelwitte:

- Om die bevallingspraktyke wat vroue se ervaring beïnvloed, te identifiseer.
- Om vroue se ervaring met betrekking tot ondersteuning tydens bevalling te beskryf.
- Om vroue se ervaring rondom gesondheidversorgers se ingesteldheid tydens bevalling te identifiseer.
- Om te identifiseer of daar aan vroue se bevallingsbehoeftes voorsien is.

’n Kwalitatiewe beskrywingsbenadering is toegepas om vroue se ervaring in twee staatshospitale te ondersoek. Die populasie is vroue wat die betrokke hospitale ses weke ná geboorte vir ’n postnatale ondersoek besoek het. Doelbewuste steekproefneming is gebruik om 12 vroue te kies wat ingestem het om aan die studie deel te neem.

Data is deur ’n semi-gestruktureerde onderhoudsgids ingesamel en daar is ’n onderhoud met drie deelnemers per dag gevoer. Lincoln en Cuba se kriteria van geloofwaardigheid, oordraagbaarheid, bevestigbaarheid en afhanklikheid is gebruik om vertroue te behou(Polit & Beck, 2012:560).

Data is deur ses fases van tematiese analise ondersoek, soos deur Braun en Clarke,(2012:57).

beskryf. Ses temas het aan die lig gekom : Kliënte se ervaring met bevallingspraktyke en dienste, ondersteuning, versorger se ingesteldheid en kommunikasie, kliënte se sorgbehoeftes, kliënte se betrokkenheid in sorg, en die kraamsaal se omgewing en menslike hulpbronne.

Die studie het aan die lig gebring dat daar swak ondersteuning tydens bevalling is, aangesien vroedvroue ander pligte het en metgeselle nie in staatshospitale toegelaat word nie. Daar is nie aan die kliënte se behoeftes voldoen nie, as gevolg van vertragings in gesondheidsorg, ’n tekort

aan personeellede en ’n tekort aan betrokkenheid. Die hospitaal se omstandighede is as ongunstig teenoor vroue en hul pasgeborebaba beskryf.

Gevolgtrekking: ’n Tekort aan vroedvroue dra by tot die swak gehalte van gesondheidsorg wat tot ’n negatiewe ervaring lei. Daar is ’n behoefte om die ondersteuningstruktuur tydens bevalling te verbeter indien infrastruktuur en kliënte vloei dit toelaat,

Sleutelwoorde: bevallingservaring, vroue se bevallingservaringe, gehalte van moederlike gesondheidsorg

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LIST OF ABBREVIATIONS

CHAL	Christian Health Association of Lesotho
CINAHL	Cumulative Index of Nursing and allied health literature
LDHS	Lesotho Demographic Health Survey
MDG	Millennium Development Goals
PBF	Performance Based Financing
WHO	World health organization

CHAPTER 1:
FOUNDATION OF THE STUDY

1.1 INTRODUCTION

Maternal mortality has remained one of the critical health concerns in the world and antenatal and intrapartum complications are considered as the main causes to high maternal mortality which is estimated to 830 maternal deaths per day (World Health Organisation (WHO), 2016:1). In the fight against the global maternal death burden, recommendations were made to improve facility deliveries and access to skilled care during childbirth and it was prioritised as a second indicator of progress in the Millennium Development Goals (MDG) (Bradley, McCourt, Rayment and Parmar, 2016:157). However, evidence has shown that increased access to facility delivery alone does not improve maternal outcomes, but that women should be given quality services throughout the birth continuum (Banks, Karim, Ratcliffe, Betemariam and Langer, 2017:318). In some countries like the Dominican Republic, Miller and Lalonde (2015:S50) noted high maternal deaths despite the 98 per cent increase in skilled care. The high maternal death was associated with disrespectful and poor quality care that was given to labouring women.

Research has shown that disrespectful and abusive care that women encounter in health care setting has a more detrimental effect on use of facility delivery leading to high maternal death (Miller and Lalonde, 2015:S50). Banks *et al*. (2017:318) emphasise that disrespectful care and abuse during childbirth have a negative impact on quality care and poses as a threat for achieving positive maternal outcomes. Miller and Lalonde (2015:S50) identified that disrespect and abuse have a direct and indirect link to maternal death. The direct link is evident in cases where women are not given person-centered care during childbirth. Women may report symptoms to healthcare providers who may fail to provide individualised care and serious complications may be missed leading to adverse maternal outcomes. Maternal mortality as one of the adverse maternal outcomes is linked to poor quality of childbirth services. The United Nations has advocated for prevention of human rights violations during childbirth to prevent maternal deaths and has therefore provided technical guidance for the implementation of a human rights based approach (Miller and Lalonde, 2015:S49). Furthermore, the World Health Organisation has developed a framework that addresses quality care around the period of childbirth. The framework indicates that there are two interlinked dimensions for quality of care; the provision of quality care by health workers and the experience of care by women. In order to achieve quality care the two dimensions

have to complement each other (WHO, 2016:1). All stakeholders, including women as the consumer, have to be involved in the assessment of maternal and newborn health care services in order to improve quality of care.

The WHO mentioned that in the past two decades there has been an increase in interventional practices during childbirth which are aimed at improving outcomes for mothers and their newborns, and this has been found to affect women negatively (WHO, 2018:1). Behruz, Hatem, Fraser, Goulet, Li, and Misago (2010:1) indicate that the high intervention rate affects women's experiences of childbirth and reduces their sense of control over what is regarded as a physiological process. Behruzi *et al*. (2010:1) recommend humanisation of the childbirth process to make childbirth a positive and satisfying period for woman and their families. This emphasises the need for respectful care and the involvement of women in their care so that they can make informed decisions by understanding the risks and implications of the interventions.

The study will be conducted in Lesotho, a small kingdom country in sub-Saharan Africa which is surrounded by Republic of South Africa. It is classified under the least developed countries globally (Millennium development goals (MDG) status report, 2015:XI). The population is estimated to two million people and the maternal mortality ratio is around 1,024 per 100,000 births ((Ministry of Health, Lesotho Demographic Health Survey, (LDHS), 2014:280). Even though Lesotho did not meet the MDG 5, there have been improvements in some of the secondary indicators like an increase in access to antenatal care from 90 per cent in 2004 to 95 per cent in 2014 (Lesotho Demographic Health Survey, 2014:124), and an increase in access to skilled care from in 55 per cent in 2004 to 78 per cent in 2014 (Millennium Development Goals Status Report, 2015:54). Nevertheless, Lesotho is still battling with maternal death reduction where only about a one per cent reduction rate has been achieved (Machira and Palamuleni, 2018:25). Therefore, it is essential to identify women's childbirth experiences in order to improve quality of childbirth services.

1.2 BACKGROUND AND SIGNIFICANCE OF THE PROBLEM

The perceived quality of care is crucial as it determines women's use of the healthcare services. Shimpuku, Patil, Norr and Hill, (2013:463) have found that previous experience of the health services affects future decisions about accessing these services. In a systematic review done on respectful maternity care, Shakibazadeh, Namadian, Bohren, Vogel, Rashidian, Pileggi, Madeira, Leathersick, Tuncalp, Oladapo, Souza, and Gulmezoglu (2017:2) indicated that skilled care is

considered a priority in the prevention of maternal death, however access to skilled care may be hampered by reports of mistreatment and abuse, especially in low and middle income countries.

Miller and Lalonde, (2015:S50) indicate that when women have experienced disrespectful maternity care and abuse, they avoid facility delivery even when they experience complications, or they may influence people close to them, thereby leading to maternal death. In a study done in Nepal, Karkee, Lee and Pokharel (2014:1) found that women's choice of healthcare services is determined by their previous experience or the experience of people close to them.

1.3 RATIONALE

Shimpuku *et al*. (2013:462) indicate that sub-Saharan Africa constitutes 11 per cent of the world population yet it bears the highest global maternal death burden. Afulani, Kirumbi and Lyndon (2017:1) noted that about 66 per cent of maternal deaths occur in sub-Saharan Africa and the poor outcomes are due to gaps in the provision of quality maternal health services which includes poor person-centered care. However, Machira and Palamuleni (2018:25) reveal that some countries in sub-Saharan Africa like Zambia, Tanzania and Mozambique, have achieved a remarkable decrease in maternal mortality due to improved quality of care. Nevertheless, in the same region Lesotho and Malawi have had a very slow progress of 1.0 per cent and 1.6 per cent respectively in maternal death reduction.

Childbirth is a critical period that needs special attention as most complications that cause maternal mortality occur around this time (WHO, 2018:1). The World Health Organisation recommends the shift of attention from disease-orientated care to person-centered care. In this regard, it is critical to assess whether healthcare professionals meet women's expectations in childbirth so that policy changes can be women-centered (Shimpuku *et al*., 2013:463). It is critical to involve women in their own care and respect their rights so that they can make informed decisions with a clear understanding of the interventions, their risks and implications.

1.4 RESEARCH PROBLEM

Hospital or facility-based delivery is one of the strategies recommended by WHO to increase access to skilled care and decrease high maternal death, especially in developing countries (WHO, 2016: 5). However, Bishanga, Masenga, Mwanamsangu, Kim George, Kapoloqwe, Zoungrana, Rwegasira, Kols, Hill, Rijken and Stekelenburg, (2019:2) indicate that the increase in facility delivery showed no impact on the decline of maternal deaths due to poor quality of care. Afulani *et al.* (2017:1) mention that poor person-centered maternity care may contribute directly

or indirectly to poor maternal outcomes which lead to high maternal deaths, and yet few studies have been done in a low-resource setting to identify women's childbirth needs.

According to the Kingdom of Lesotho's, Millennium Development Goals Status Report, (2016:56) there are three main factors are linked to maternal mortality in Lesotho; Delay to access health care services, delay to reach healthcare facilities and delay to receive appropriate management or referrals to appropriate level of care. In Lesotho, women are complaining of unsatisfactory childbirth services in health facilities, especially in public hospitals. Mostly the views are expressed on local radios, newspapers and social gatherings. There is a need to access how women feel about their childbirth experiences, especially in public hospitals, and what led to delayed access to facility deliveries. In Lesotho there is currently no published study on women's childbirth experiences in public hospitals. Therefore, there is a need to access how women perceive and experience the childbirth services in public hospitals.

1.5 RESEARCH QUESTION

What are women's childbirth experiences in public hospitals in Lesotho?

1.6 RESEARCH AIM

The study aim is to explore how women experienced childbirth care services in two public hospitals in Lesotho.

1.7 STUDY OBJECTIVES

The objectives of the study are:

- To identify negative or positive childbirth practices or services that can influence women's experiences in childbirth.
- To describe women's experiences in relation to support given during childbirth.
- To identify women's experiences about their healthcare provider's attitude during their childbirth.
- To identify if women's childbirth needs were met.

1.8 RESEARCH METHODOLOGY

An overview of the study methodology is discussed below and more in-depth discussion provided in chapter 3.

1.8.1 Study design

A qualitative approach with a descriptive design was done to explore women's childbirth experiences in two public hospitals in Lesotho. The selected approach was most appropriate as it enabled women to express their in-depth childbirth experiences in public hospitals. Grove, Burns and Gray (2015:77) attest that a descriptive design allows an individual to give information and insight into a clinical problem.

1.8.2 Study setting

The study was done in two public hospitals in Lesotho, one in the northern region and one in southern region of the country.

1.8.3 Population and sampling

The population of the study was adult women who have given birth in public hospitals in Lesotho. The participants were recruited during their six weeks post-natal clinic visit in the participating hospitals. Eight participants were recruited from each hospital. Purposive sampling was applied; age, parity and educational background were used in selection of participants in order to include variety in experiences. A total of twelve participants were interviewed.

1.8.3.1 Inclusion criteria

- Women who were 18 years and older and had delivered at the participating public hospitals.
- Women who had delivered in a public hospital in a period of six weeks prior to the interview.

1.8.3.2 Exclusion criteria

- Women with a condition that prevented them from participating meaningfully.
- Women who were diagnosed with psychological conditions such as depression, as the disease process can affect their judgment.

1.8.4 Data collection tool

A semi-structured interview guide was used to collect data. Interview guide ensured consistency in the collection of data from all participants (see attached Appendix 1). The tool was designed in line with the objectives of the study which were supported by literature. The tool was validated by the academic supervisor and tested during a pilot interview to assess whether it responded to the objectives of the study.

1.8.5 Pilot Interview

The pilot interview was performed to determine the feasibility of the study methodology and assess the clarity of the interview questions thereby making necessary adjustments to improve the study (Brink, Van der Walt and Van Rensburg, 2012:57). Two participants who had similar attributes to the study population were engaged in the pilot interview. Participants made shallow expressions therefore probing questions were added to the main interview questions to encourage participants to express their childbirth experiences in more in-depth.

1.8.6 Trustworthiness

Validity of the study was maintained by applying the four principles of trustworthiness; transferability, dependability, confirmability and credibility as described by Lincon and Cuba in De Vos Delport, Fouch and Strydinol (2011:331).

1.8.7 Data collection

Recruitment was done during the six weeks post-natal check-up in both participating hospitals. Women who agreed to take part in the study were given detailed information about the study and they signed a consent form (see appendix 2). Women who consented were interviewed to explore their childbirth experiences in the two participating public hospitals. Women were asked their preferred area for conducting the interviews and they agreed to be interviewed in the hospital premises. In hospital A, interviews were done in a room which was not frequently used. In hospital B, interviews were performed in a separate room which was near the maternal and child health corner. An audio tape recorder was used to record data during the interview. The researcher interviewed five women in hospital A and seven women in hospital B: a total of 12 participants were interviewed as data saturation was met. According to Brink *et al*. (2012:173), data saturation occurs when subsequent participants do not raise any new information which was not mentioned by previous participants.

1.8.8 Data analysis

Data was analysed manually using thematic analysis following the six phases of data analysis: “Familiarisation with data, generating initial codes, searching for themes, reviewing potential themes, defining and naming themes and writing the report” as described by Braun and Clark (2012:60).

1.8.9 Ethical consideration

An approval to conduct the study was granted by the Stellenbosch University health research and ethics committee, application number S19/03/065 (see Appendix 3 and 4). The Lesotho ethics clearance committee also granted an approval to conduct the study in Lesotho, reference number ID 129-2019 (see Appendix 7), and the managers from the participating hospitals gave permission to conduct the study in the two participating public hospitals (see Appendix 8 and 9). Benchmarks for ethical research were applied and aligned with ethical principles that guide research in health care. Women's' rights were respected.

1.8.9.1 Right to self determination

a) Principle of autonomy

The study involved women as members of the community with the idea of exploring their experiences regarding childbirth in public hospitals. The principle of autonomy ensured respect for individual person and allowed women to make their own choices based on their convictions (Pera and Van Tonder, 2011:54).The study's purpose was fully explained to participants and women were informed of their right to either give consent to participate in the study or withdraw participation without consequences (Grove *et al*., 2015:101).

b) Principle of informed consent

Informed consent was maintained by sharing information about the study with the participants, assessing whether the participants comprehend and understood the information in order to make informed choices (Grove *et al*., 2015:111). Women who agreed to participate in the study signed consent forms to be referred to the researcher. Participants were given study information leaflets and their informed written consent in English or Sesotho languages was required before the interviews.

1.8.9.2 Right to confidentiality

The participants were assured that all the information shared with the researcher was confidential. Grove *et al*. (2015:107) indicate that participants' identities should not be linked to their responses, therefore the hospitals' names and participants' names were not used, and instead numbers and alphabets were assigned to hospitals and participants. Interviews were conducted in the hospital setting or at the place and time of the participants' choice. The recordings and transcripts have been stored in a secure place under lock and key for five years.

1.8.9.3 Principle of beneficence

It was maintained by doing good to people, protecting their rights and preventing harm (Grove *et al*., 2015:108). The study will benefit the participants and the community at large as the study results will be used to improve the childbirth services in participating hospitals. The researcher has maintained the wellbeing and comfort of the participants during the interviews. She took into consideration the participants' emotions and no case of emotional breakdown was noticed during the interviews.

1.9 OPERATIONAL DEFINITIONS

1.9.1 Childbirth

Childbirth is the process which starts with the onset on true signs of labour until the delivery of the baby, placenta and membranes, and involves the immediate care of the mother and the newborn (Dictionary.com:n.d).

1.9.2 Facility based deliveries

Birth that occurs at the healthcare Centre or hospital and is facilitated by a trained healthcare provider, midwives, doctors and obstetricians (Moyer, 2012:XI).

1.9.3 Skilled birth attendant

This is a health professional who has been trained and has acquired skills in the management of pregnancy, labour and post-partum care and has been authorised by the regulating body (Shimpuku *et al*., 2013:462).

1.9.4 Respectful maternity care

It is an approach that takes into consideration the unique needs and preferences of women during childbirth. It prioritises their rights and ensures access to quality care through evidence-based practices (Shakibazadeh *et al*., 2017:2).

1.10 DURATION OF STUDY

Ethics approval from Stellenbosch University's health research and ethics committee was granted on 14 July 2019 and approval from the Lesotho clearance committee was received on 8 April 2019. The pilot study and data collection were done in August 2019.

1.11 CHAPTER OUTLINE

Chapter 1: Foundation of the Study

Chapter 1 includes the background and significance of the study and an overview of the research questions, objectives, research methods and designs.

Chapter 2: Literature Review

This chapter discusses the depth findings of the various literature reviewed including books, articles, the guidelines, recommendations and midwifery standards.

Chapter 3: Research Methodology

Chapter 3 gave detailed description of the research methodology.

Chapter 4: interpretation of findings

The chapter describes the findings of the study.

Chapter 5: Discussion, Conclusion and Recommendations

This chapter is based on the recommendations made as a result of the study findings.

1.12 THE STUDY SIGNIFICANCE

This study is significant as it engages women as consumers of the childbirth services to express their experiences and give recommendations into their preferred care. It also identifies gaps in childbirth service provision that may cause a poor uptake of the services. The results will bring new knowledge on essential aspects of respectful quality care that women value during childbirth and also identify gaps in the provision of quality care as per women's perspectives. Moreover, the study will clarify women's needs during childbirth to improve the utilization of maternal health services thereby leading to improved maternal health outcomes during childbirth.

1.13 SUMMARY

Chapter one laid the foundation of the study by giving an introduction into the study, it described the problem statement and the rationale for conducting the study. The aims and objectives of the study were explained. A brief discussion of the research methodology and ethical consideration applied in the study was discussed. The study outline was tabulated.

1.14 CONCLUSION

Maternal death remains a threat to women of childbearing age in sub-Saharan Africa, despite efforts like formulation and implementation of quality standards, strategies and recommendations to reduce the high maternal death rate. However, the impact does not yield the expected results of reduced maternal mortality therefore there is a need to further investigate the quality of care offered in public hospitals. The World Health Organisation emphasises the importance of quality of care during childbirth, it is therefore essential to assess the experiences and perceived quality of care from the women who have delivered in public hospitals as the major childbirth care entity in Lesotho. The study's results have identified the strengths and gaps in the quality of childbirth services and have given recommendations towards improved maternal health outcomes.

CHAPTER 2:
LITERATURE REVIEW

2.1 INTRODUCTION

A literature review entails searching for relevant data pertaining to a topic under study; it includes appraising the data and synthesising findings of the studies (Grove *et al.*, 2015: 163). In order to identify women's childbirth experiences in Lesotho, a literature review was done before conducting the study, during the study, and after the study. The purpose of conducting the literature search is to identify and explore the experiences of women from across the globe regarding their experiences of childbirth and to inform the current study of the discrepancies in the provision of quality childbirth services, especially in low resource countries. A literature review also serves as the basis for the study in order to identify important aspects to women during their childbirth care.

2.2 SELECTING AND REVIEWING THE LITERATURE

The literature review was gathered over a period of 21 months; before, during, and after conducting the study. Electronic databases used included: Stellenbosch university library and an information Centre (SUN search), Public Medline, Elton B. Stephens's company research database (EBSCO host), Cumulative index of nursing and allied health literature (CINAHL), and Science direct, and Google scholar. Key words used included; childbirth experiences, women's labour experiences and quality care during childbirth. The articles and books that were used were published between 2010 and 2019. Forty-six relevant articles were used as well as the World Health Organisation standards and protocols that relate to childbirth.

2.3 FINDINGS OF THE LITERATURE REVIEW

The literature review will be discussed under the following headings:

- Background of the childbirth care services in Lesotho
- Quality care
- Healthcare providers' attitudes
- Informed decision making
- Continuous support
- Cultural sensitivity
- Childbirth practices
- Healthcare facility infrastructure and resources

2.4 BACKGROUND INTO THE CHILDBIRTH CARE SERVICES IN LESOTHO

In Lesotho, the healthcare system is governed and directed by the Ministry of Health (MOH), which has the sole responsibility of overseeing that the general health of the nation is restored. However, like many underdeveloped countries in sub-Saharan Africa, Lesotho is facing many challenges that include a persistently high maternal mortality rate and high HIV prevalence. According to the kingdom of Lesotho Millennium Development Goals Status Report, MDG (2016: XIX), the high maternal mortality rate is declared as a national crisis. Maternal death has increased over the years, in 1990 there were 307 deaths per 100 000 births, in 2007 maternal death increased to 1,143 deaths per 100 000, and in 2014 there was a slight decrease of 1,024 deaths per 100 000 births. The findings further indicate that the high maternal mortality is associated with three delays; a delay in seeking health care, a delay in reaching care, and a delay in receiving care (The Kingdom of Lesotho, Millennium Development Goals Status Report, 2016:56). This study serves as a subjective review of women's childbirth experiences, which can inform the healthcare sector of the consumers' views on perceived care.

Despite the high maternal death rate, positive aspects have been identified in maternal health services in Lesotho, like the increased access to antenatal healthcare and improved facility-based deliveries. Ministry of Health, Lesotho demographic health survey (LDHS), (2014:124) has shown that the majority of women received antenatal care from skilled healthcare providers in 2004, 90 per cent of women attended an antenatal clinic, and in 2014 95 per cent accessed the antenatal clinic services, however, only 40 per cent had their first visit during the first trimester. Furthermore, Ministry of health, LDHS (2014:127), indicate that access to facility-based childbirth services has improved over the years, by 62 per cent in 2009 and 77 per cent in 2014. Out of the 77 per cent facility deliveries in 2014, midwives attended 61 per cent.

Globally, nurses and midwives constitute the largest percentage of the health care workforce and their roles are regarded as critical to the health of the population (Indirect.gov.uk, 2019:n.d). In Lesotho, Healthcare service delivery mainly operates through nurse driven service delivery, with the majority of the health sector providers being nurses and midwives, with an average of 11.58 nurses per doctor in the public health sector. Moreover, the ratio of the doctors to the population is 0.9 per 10 000 people, and the nurse/midwife's ratio to the population is 10.2 per 10 000. These rates are below the recommended standards by the World Health Organisation (Lesotho public health sector expenditure review, 2017:23).

2.4.1 Economic status of the country that affects childbirth services

Lesotho is a low income country with scarce resources, there is a high unemployment rate in the country that has contributed to a decline in the economy, with more than 50 per cent of the population living below the poverty line (The Kingdom of Lesotho millennium development status report, 2015: xvii). Therefore, most women access healthcare services from government entities as the childbirth services are levied (MDG status report, 2016: 61). However, some women still deliver at home. In the five years before the 2014 demographic health survey, 77 per cent of deliveries took place in healthcare facilities and 23 per cent were home deliveries. Of the 77 per cent total facility deliveries, 70 per cent were conducted in public health facilities (Ministry of Health, (LDHS), 2014:126). The public health facilities constitute a major portion of maternal healthcare service delivery; of the total 265 healthcare facilities in Lesotho, the government operates at 90 primary health centres and 9 general hospitals, while the Christian Health association of Lesotho (CHAL) has 74 primary health centres and 8 hospitals as the second largest healthcare operator (Lesotho public health sector expenditure review, 2017:22).

2.4.2 The healthcare system barriers in public childbirth care

Poor infrastructure and inadequate human resources were identified as some of the challenges that hinder the provision of quality maternal health services in Lesotho (MDG status report, 2016: 61). There are infrastructure constraints in public health facilities whereby the labour room does not accommodate women as individuals, instead screening curtains are used to provide privacy, birth companions or relative support is not practiced in public facilities except for the minority population that can afford private practice. While several studies have emphasised the benefits of support, the concept is not maximised in public health facilities in Lesotho.

2.4.3 Accessibility of childbirth services within the communities

Lesotho is a mountainous country with the majority of the population, about 75 per cent, living in rural areas (MDG Status report, 2016:XI). Lesotho's terrain is one of the significant barriers in access to childbirth services for women in rural areas, whereby some women have to travel for more than three hours by foot or on horseback to access childbirth services (Satti *et al.*, 2013:10). The inaccessibility of the childbirth services has a negative impact on maternal health as it was found that contributing factors to maternal deaths included a delay in seeking help and a delay in reaching health facilities (MDG Status report, 2016:56). The MDG status report notes that one of the lessons learned from the review was to help women from rural, hard to reach areas, with financial aid for transport payment and labour services in order to improve maternal health services (MDG Status report, 2016:63).

Furthermore, maternity homes have been used as one strategy to improve access to skilled obstetric care. Maternity waiting homes are lodging facilities for pregnant women who live in remote areas that accommodate them when they are near term (Wild *et al.*, 2011). The concept was introduced in developing countries by the World Health Organisation as a strategy to reduce maternal deaths in the 1960s (Satti *et al.,* 2013:7). However, in the systematic review done in low- and middle-income countries, barriers were identified that contribute to the poor implementation of maternity homes. These factors include a lack of family companionship and poor sensitivity to cultural practices at the facilities (Penn-Kekana, Pereira, Hussein, Bontogon, Chersick, Munjanja & Portela 2017:1).

Lesotho has adopted maternity waiting home concept, over the ages, where expected mothers from rural communities are given accommodation to stay within the hospital premises when they are close to term or after a 36 week gestation period (Satti *et al.*, 2013:11). The use of maternity homes has however been declining due to a lack of food in other health facilities in Lesotho (Satti *et al.,* 2013:15). Similarly, in a study done in Zambia, women in maternity waiting homes were expected to cook food for themselves and this affected implementation (Chibuye *et al.,* 2018:5). Partners in health, a non-governmental organisation, has built maternity homes in seven hard to reach rural facilities in Lesotho and the implementation was facilitated by the provision of food to reduce the extra costs of sharing food with family members (Satti *et al*., 2013:16). However, there is a gap in the subjective viewpoint of women's perceptions with regard to separation from family support and how it affects their experience.

2.5 QUALITY CARE

Quality of care is one of the strategies aimed at improving childbirth care and reducing maternal mortality, the strategy emphasises the healthcare provider's competency in delivering services and the consumer feedback on the care provided. The WHO (2016:14), define quality care as care that is safe, effective, efficient, equitable and women centered, and should improve and bring about desired health outcomes to the population. The WHO has identify two important aspects of quality care; the quality of care rendered by healthcare providers and the experience of care by women and their families (WHO, 2016:15). The purpose of this literature review is to identify how women experience their childbirth care.

There is a complex relationship between experience of care and maternal outcomes; the availability of essential maternal services alone is not adequate to prevent maternal deaths, women should be satisfied with the quality of care rendered to them so that they may utilise the

services (WHO, 2016:5). The WHO further explains that every woman should be given skilled and evidence-based care together with a positive healthcare provider attitude. Redshaw *et al.*, (2019:2) indicate that women's views and experiences about the quality of care in childbirth is critical because the health fraternity has grown and maternity services have evolved over the years. The needs of the population have also changed with time, hence why from a policy perspective it is important to re-assess the quality of care rendered during childbirth. According to Lunda *et al.* (2018:1), poor person-centred care affects the quality of care that the women experiences, leading to a poor maternal outcome. Therefore, there is a need to undertake more studies in low resource countries, which are most heavily affected. In a study done in South Africa, Oosthuizen *et al.* (2017:5) have found that some socio-demographic variables, like low educational status, teenage pregnancy, and young adult pregnancy were more heavily associated with negative childbirth experiences.

Childbirth is identified as a significant period for the survival of women as most complications that cause maternal death are evident around this time (WHO, 2018:1). Improving the quality of care is a significant focal point to end preventable maternal deaths (WHO, 2016:5). Midwives should consider women's childbirth needs to achieve quality care, this includes emotional and physical informational and a good women-midwife relationship (Iliadou, 2012:386).

2.5.1 Effective communication

The WHO's guidelines for Intrapartum care for a positive childbirth experience states that, even though there is no standardised description of effective communication in childbirth, there are certain aspects of care that are critical in the healthcare provider's and women's interactions. This entails the healthcare provider properly introducing herself to the woman and her relatives, information sharing about care rendered, clear messaging in a woman's language, providing support, facilitating informed choices, and preferred birth companionship (WHO, 2018:25). Good midwife and woman communication facilitate individualised care and the uptake of the childbirth care services (Fraser *et al.*, 2010:22).

However, studies on women's experiences of childbirth have identified a major gap in communication in practice as opposed to the WHO's recommendations. In a study done in Serbia women reported that healthcare providers do not communicate with them when providing care, instead women only overhear conversations among healthcare providers discussing their care. For instance, they reported that they were not informed of labour progress and implications of the interventions, (Stankovic, 2017:808). Moreover in Tanzania, women reported a lack of

communication during childbirth and indicated that aspects of care, like preferred birth position or companionship, were not adequately explained so that they could made their choices (Bishanga *et al.*, 2019:2). The authors indicate that the healthcare providers should understand the implications of sharing information with women as it facilitates informed choices and empower women.

2.6 HEALTHCARE PROVIDERS' ATTITUDES

Literature has identified that the healthcare providers' attitudes are one of the critical determinants of women's satisfaction in childbirth. In a systematic review that was done, including 137 countries, on women's satisfaction in childbirth, Vedam *et al.* (2017:202), indicate that the healthcare providers' attitudes and behaviors had more impact on how women experience childbirth care than their individual characteristics, like demographic information, interventions done during childbirth, and their physical environment.

The role of a midwife in childbirth is described as the most important aspect of care. Lunda *et al*. (2018:2) explain that being a midwife means being with women during childbirth, which also entails a positive and non-judgmental caring attitude. That is to say that when a woman is assisted by a healthcare provider with a good attitude it will make them feel empowered and encouraged to undergo labour, which ultimately affects their childbirth experiences. In maternal and child health, a healthcare provider's competency is valued as it has a significant impact on childbirth outcomes. However women have highlighted that competency alone does not fulfil their positive childbirth expectations; they value the healthcare provider's personal characteristics, such as a non-judgmental attitude and openness (Jerkins *et al.*, 2014:216). These indicate that midwives have an important role of providing quality healthcare services to the community as satisfaction regarding childbirth services is mostly determined by their attitudes (Oosthuizen, *et al*., 2017:2).

Several studies have identified negative healthcare provider attitudes during childbirth, mostly in low resource countries. Hatamleh *et al.* (2013:505) have mentioned that women describe midwives as impolite and unfriendly; they reported neglect, shouting and being assisted without proper introductions. Chadwick *et al.* (2014:864) also found that poor interpersonal relations between midwives and women contributes to negative experiences. Women reported that midwives were rude, shouted, and punished them for any acts that were against their instructions and, as a result, women indicated that they felt humiliated and all alone without support needed during the birthing process. Adatara *et al.*, (2019:4) have also identified that some women reported negative childbirth experiences, like scolding, disrespect, and abuse, however, they

mentioned that they were not in a position to express their feelings due to the fear of creating conflict with their healthcare provider. They believe that if they express their feelings it can affect the quality of care they receive. Vedam *et al*. (2017:202), highlight an important concept, that there is normalised disrespect and abuse during childbirth, women may perceive care as disrespectful while healthcare providers do not identify it as such. In some instances, women may identify certain aspects of care as disrespectful while some do not. This makes the identification of disrespectful care as complex.

In the same way, women who have delivered their children in developed countries with adequate resources, like the United Kingdom, the United States of America, and Australia, have also reported poor childbirth care. In a study done in the United Kingdom concerning women's experiences regarding giving birth at a hospital, the majority of women reported a negative attitude from their healthcare provider. Women described the care as insensitive and threatening as they were treated as minors who were incapable and this resulted in feelings of shame and inferiority (Vedam *et al.,* 2017:202). However, in a study done in Western Australia, some women reported a positive staff attitude, they indicated that midwives made time for them and they were offered person-centred care which was responsive to their needs rather than routine based care which is intended for task completion (Jenkins *et al.,* 2014:216).

2.7 INFORMED DECISION MAKING

Literature has shown a gap in the facilitation of informed consent by healthcare providers. Hatamleh *et al.* (2013:501), explain that women's childbirth experiences are related to their capability to give informed consent. Women who did not participate in decision making regarding their care were more dissatisfied with the care they received. On the contrary, women who were treated with respect and who were involved in their care reported to be satisfied with the care they received and had a trusting relationship with their healthcare providers. A poor midwife-patient relationship hampers women's choices, leaving them with anxiety and a loss of worth, women indicated that they were examined without their consent and that they were not informed of the findings (Chadwick *et al.*, 2014:865).

In a study done in South Africa, Bradley *et al.,* (2016:157) indicate that women perceived that they were treated as bystanders and not partners and that they felt isolated, not being involved in their care. They further explained that services were not individualised but were hospital orientated. Vedam *et al.* (2017:202), also found that women were not offered adequate information to facilitate informed decision making, instead decisions were made for them which

were contrary to their preferences. Pazandeh *et al.* (2017:66), highlight that most women felt passive during childbirth as they were not in a situation to make their own decisions. However, some women indicated that they had confidence in their healthcare provider as they know more about childbirth, and hence, are in a better position to make good decisions. This emphasises the need for humanisation of childbirth, women's rights should be respected and women should be involved in their care.

2.8 CONTINUOUS LABOUR SUPPORT

Kozhimannil *et al.* (2017:2) explain continuous labour support as the physical and psychological aspects of care given to a woman in labour to empower them to have a sense of control over the labour process and facilitate informed choices. Hodnett *et al.*, (2014:3) have highlighted that continuous support alleys anxiety and fear during childbirth. These two factors are associated with increased levels of epinephrine, a stress hormone which has an impact on the physiological process of childbirth and may lead to fetal and maternal complications. Iliadou (2012:386) emphasises that continuous support creates a stable emotional state for women to undergo normal childbirth and they identified the four dimensions of support that women aspire in their childbirth; physical support, emotional support, information giving, and advocacy.

Continuous support during childbirth was found to have a positive impact on labour and various benefits were identified; there is a reduced need for interventional practices, improved maternal satisfaction, improved bonding, and reduced anxiety during childbirth (Lunda *et al*., 2018:1). Continuous support also facilitates open channels of communication and forms the basis for a trusting relationship where women are able to ask questions whenever there is a feeling of uncertainty (Lewis *et al.*, 2016:2). Even though the benefits of continuous support are widely documented, there are constraints in some countries that hamper effective implementation. Hodnett *et al*., (2014:4) have found that in many low resource countries women are not allowed to have a birth companion, be it family member or doula. Stankovic (2017:805) indicates that in Serbia a majority of hospitals do not allow birth companions during childbirth due to infrastructure factors which may expose women and compromise their privacy.

In standards of improving the quality of maternal health, the WHO emphasises that continuous support is a component of experience of care, therefore, women should be allowed to have a birth companion of their choice so as to enhance their confidence as childbirth is an individual process that has a special meaning to women (WHO, 2016:23). Different types of support were identified in the literature review and women's choices differ based on their individual preferences.

2.8.1 Female family member or friend support

In ancient times, across all cultures, a woman was supported by other women during childbirth and this improved continuous support and the humanisation of childbirth. Support was identified as physical presence, emotional presence, and coping strategies (Hodnett *et al.,* 2014:2). In a study done in Bangladesh on women's companions of choice, the majority of women preferred a female family member as their birth companion, such as their mother, sister, or mother in law. It was indicated that these may be influenced by country based norms as maternal issues are regarded to be women orientated (Perkins *et al.*, 2019:14). Moreover, Lunda, *et al.,* (2018:4) claims that women appreciate support from their female relatives, especially their mothers, as they have undergone the childbirth process and they understand their pain.

Several studies have found that women feel more secure around family members during childbirth as these people know them much better. Women indicated that delivering at a healthcare facility was not a guarantee for receiving high quality services as some women still deliver on their own without the support of a midwife. Therefore, they would appreciate the presence of someone close to give them support (Bradley *et al.* 2017:170). In the past when women were offered community-based childbirth care, they got continuous support from their community and family and they felt well cared for. However, as modern maternity units are introduced, childbirth care become fragmented and dehumanised (Aune *et al.*, 2012:89). From the 20th century, as women delivered in hospitals, there has been a concern of dehumanisation of childbirth in low-, middle-, and even high-income-countries (Hodnett *et al.,* 2014:2). This calls for the inclusion of family support in hospital and facility-based childbirth services.

2.8.2 Healthcare provider support

Continuous support by a midwife during childbirth is associated with many benefits like information sharing between the midwife and the woman, emotional support, increased chances of spontaneous deliveries, and the increased boding and emotional stability of the family (Aune *et al.*, 2012:89). The authors emphasise the importance of good midwife-woman relationship as the relationship forms the basis and affects all other aspects of care. If there is no good relationship, support, communication, and information sharing will be hampered.

Women explained that midwives are more focused on the technological and medical aspects of labour and are unable to provide direct support (Lunda *et al.*, 2018:4). In a study done in Sweden, the findings revealed that midwives too often care for more than one woman during childbirth, making it difficult to provide continuous support during childbirth. Hodnett, *et al.*, (2014:4) also

argue about the capabilities of midwives to provide continuous support as they have to care for more than one woman in labour and also have other responsibilities, like record keeping and the technological monitoring of labour. Even though midwives' support was viewed as limiting, it was found that the use of other lay support structures, like family members or the woman's partner, was associated with additional burdens to health providers (Bohren, 2019)

Women reported a lack of support from healthcare providers and indicated that it is not easy to build a meaningful relationship with midwives as they constantly change and it is not easy to determine who will be there during their labour. Furthermore, women said they have to repeat their story over and over again to midwives and this creates unstable relations and, therefore, they feel unsupported (Hatamleh *et al.,* 2013:506).

2.8.3 Birth companion or doula support

A doula is a non-healthcare professional who is trained to offer supportive care individualised for women during childbirth (Kozhimannil *et al.,* 2017:2). In many studies, the use of doula support was associated with low ratings of a negative childbirth experience (WHO, 2018). Women reported that doulas were an essential support system to them and their families as they provided physical and emotional support. Women with no relatives during labour described doulas as a sister in birth and appreciated their contribution (Lunda *et al.,* 2018:5). Moreover, the results of a randomised, controlled trial verified the benefits of continuous support during childbirth and indicated that, among all the different types of support, doula support had shown more benefits and increased women's satisfaction (Kozhimannil *et al.,* 2017:2). Literature has shown that a facility's environment is highly institutionalised with routines, high intervention rates, and unfamiliar faces. Therefore, doulas were found to be more efficient as they were able to buffer the hostile environment through support and companionship (Dekker, 2019).

Kozhimannil *et al.,* (2017: 2) indicate that in countries like the United States of America, doulas use was paid for and was not covered under medical aid expenses which affected their use. Nevertheless, there was an observable use of doula support between 2011 and 2012, even though it was still low, about six per cent of women accessed doula support. This gap was due to financial constraints, especially for low-income communities. On the contrary, Sorensen (2018) mentions that, in African nations, doula support has been practiced for centuries but a decline in doula use has come with the medicalisation of childbirth, which is associated with a desire to transition into the western way which is not the best for women.

2.8.4 Paternal support

In some parts of the world, paternal support and presence is not commonly practiced in childbirth due to cultural practices. However, in countries like Portugal, paternal support was implemented from as early as 1985 and there was the formation of a law that states that partners should also be considered as an integral part of the childbirth process (Coutinho *et al.*, 2016:436). A congress that was held in Uruguay 2001 has also passed a law that all women have a right to birth companionship (Hodnett *et al.,* 2014:4). Nevertheless, Ekstrom *et al.* (2013:2) have found that for partner's to play their supportive role in childbirth they also need support from healthcare providers, such as continuous reassurance and information giving. Coutinho *et al.* (2016:436) also emphasise that the healthcare team have a duty to orient the partner to maternity care as their support facilitates the humanisation of the birth process.

Partners are regarded as the ideal birth companion for women as their support improves family linkages or bonding. Partner involvement in maternal health issues is important as it facilitates the utilisation of skilled health services (Perkins *et al.,* 2019:15). When a father has witnessed the birth of their child, it gives them a sense of accomplishment and makes them value their parental role and also links the family triad from conception, pregnancy, childbirth, and the post-partum period (Coutinho *et al.,* 2016:439). In a study done in Sweden on fathers' feelings and experiences during childbirth, partners described their role as giving physical and psychological support to their partners and this made them feel needed during this important family transitional period (Ekstrom *et al.,* 2013:2).

Coutinho *et al.,* (2016:436) have highlighted that another benefit of paternal support during childbirth is emotional involvement as it makes it possible for the partner to do activities such as cord clamping. This creates special memories for the family that will stay with them forever. However, Stankovic (2017:805) reports that paternal support was not implemented in many hospitals due to infrastructural challenges and the possibility of invading other women's privacy. Lunda *et al.* (2018:5) mention that some women revealed that they needed their husband's involvement and support during childbirth as it improved their family bond and the feeling of togetherness and they also felt well cared for. However, some women did not want their husband's presence at childbirth as it is against their cultural practices and they believed childbirth is private. In a study done in Malawi it was also found that women reported a lack of support from their partners who indicated that maternal health were women's issues and should be addressed by women (Machira and Palamuleni, 2018:33).

2.9 CULTURAL SENSITIVITY

Literature has revealed that people's cultures and traditions affect their ways of life and, hence, influences their perception. Oosthuizen *et al*., (2017:2) have indicated that women's childbirth experiences are influenced by their cultural beliefs and backgrounds. Fraser *et al*., (2010:18) emphasise that, to achieve individualised care, midwives should assess a woman's cultural practices as it influences the acceptability of the services. Bawadi and Al-Hamdan (2017:188) explain that culture forms the basis for a woman's attitudes and choices, therefore, maternity care services should be culturally sensitive.

Culture sensitive care has been acknowledged and practiced in nursing since the 1950s. Madeleine Leininger, the founder of transcultural nursing, identified the essence of cultural diversity and its influence on the provision of quality care. Leininger developed a theory of culture care diversity and universality. The theory emphasises that people of each culture perceive and experience nursing care differently based on their beliefs and practices (George, 2014:430). Therefore, it is of critical importance to include this model of care in maternity care. The World Health Organisation has also recommended the inclusion of culturally appropriate practices in maternal health services to facilitate the experience of care as a component of quality care. Women should be given culturally sensitive and individualised care based on their preferences (WHO, 2015).

Globally, women engage in different cultural or traditional practices during pregnancy and childbirth with the intention of improving the health of the mother and the newborn (Sheehy *et al.*, 2016:854). It is important to understand the meaning of one's culture and how it affects behavior in order to provide culture congruent care (Wilson, 2012:11). In a study done in South Africa, it was also found that some women use traditional medicines to induce labour and it was done without the knowledge of their healthcare provider (Hastings-Tolsma, Nolte and Temane, 2018:e45). Studies have identified some of the practices that may have a different meaning in another culture. Native Americans do not braid or tie a knot on their head during childbirth, Asians do not take a bath immediately after birth, and Hispanic people remain on bed rest for three days following childbirth (Wilson, 2012:14).

Callister *et al.,* in Wilson (2012:15), confirm that culture and religion form a support structure in the coping mechanism of women during childbirth and therefore, they have to be acknowledged and incorporated into care. Wilson, (2012:16) specifies the need to understand cultural diversity and its impact on childbirth. A support system is viewed differently by women from different

cultures. For instance, the authors indicate that in Jewish and Arab culture husbands are not allowed into the birthing room, while in Hispanic and Asian culture women commonly prefer their mother's support during childbirth.

Wilson (2012:11) points out that in childbirth service providers assume all women have the same beliefs surrounding childbirth practices. This assumption affects women's experiences as their needs are not met but they feel obliged to follow their healthcare provider's expectations or their instructions to access their services. In a study done in a rural area of Bongo in Ghana, participants reported significant disrespect of their culture and tradition by healthcare providers. Women reported that they were denied their cultural practices, even when it was not harmful to their health and that of their newborn. They were also not allowed to take their placenta home after delivery but it was burned, as per hospital policies (Adatara *et al.*, 2019:7). The healthcare workers should understand women's diverse culture when providing childbirth services rather than expecting them to fit into the expected practice.

2.10 CHILDBIRTH CARE SERVICES OR PRACTICES

2.10.1 Interventional practices

The WHO (2018:12) has recommended that women should be given individualised care during childbirth with minimal interventions which are evidence-based to facilitate the positive experience of care. On the contrary, Hussein *et al.* (2018:100) found that there are high rates of non-evidence based interventions in low- and middle-income-countries which affect women negatively. Pazandeh *et al.,* (2017:63) describe that, in most parts of the world, the technocratic model of care is most dominant and is associated with frequent interventions during normal childbirth.

In a study done in Jordan, Hatamleh *et al.,* (2013:506) claim that women expressed labour as technological, where certain services like cutting an episiotomy, frequent vaginal examinations, limitation of movement, and restriction of food intake during childbirth contributed to their negative experience. Women felt that high interventional practices deny them the experience of a normal childbirth on their own terms as their choices are not considered. In one qualitative study, Hatamleh *et al.,* (2013:501) have found that childbirth is associated with many unnecessary interventions. Augmentation was done as a routine policy, where about 95 per cent of women reported that they were augmented, and this put women at risk of instrumental deliveries. Individualised care during childbirth helps in identifying women's needs, and hence, provides a positive childbirth experience.

2.10.2 Pain management

A woman's ability to cope with pain is determined by their biological, psychological, social, spiritual, and cultural aspects, therefore, midwives should take women's views into consideration (Fraser *et al.,* 2010:486). On the other hand, it was found that the level of pain that women experience in childbirth varies considerably depending on several factors, like prior childbirth experience, fear and anxiety, and cultural beliefs about childbirth and pain (Iliadou, 2012:387). The control of pain during childbirth should be woman centered as pain is perceived differently (Fraser *et al.,* 2010:488).

In a study done in Ireland, Larkin *et al.*, (2017:6) have found that women need pain relief during vaginal birth as it helps them to be in control or feel more at ease during childbirth. In this study, most women said they achieved a normal birth with the help of an epidural. On the contrary, some women felt that they were not adequately informed of pain relief methods, like non-pharmacological techniques or complementary therapies, and they felt this affected their choice of pain relief (Larkin *et al.,* 2017:6). Iranian women also described labour as extremely painful and overwhelming; some women indicated that their choice of health facility was influenced by the availability of non-pharmacological pain relief services even though they later discovered that they were not offered at night (Pazandeh at al., 2017:63).

The Model of maternity care influences the type of pain relief in childbirth. Berg, Astra Olafsdottir and Lundgren, (2012:1) have identified two aspects of care; midwifery led care which emphasises the psychosocial aspect of care where childbirth is considered a normal physiological process which happens naturally; and the medico technical approach which considers giving birth as a risk and it is associated with several interventions and control over women in labour. Logtenberg, Verhoeven, Rengerink,Siuijn, Feeman, Shellevis and Moi, (2015:2) indicate that midwifery led care is not highly associated with pharmacological pain relief and in the Netherlands low risk women are attended to under midwifery led care, if they request pharmacological pain relief they are referred to a hospital with obstetric led care. Larkin *et al.,* (2017:17) emphasise that in Ireland maternity services are musicalised and a hospital-based model of maternity care is mostly utilised; however, the authors indicate that midwifery led care has been associated with positive childbirth experiences. The Irish government has published a strategy that women be given the liberty to choose their preferred childbirth pathway as long as it normalises pregnancy and childbirth.

2.11 HEALTH FACILITY INFRASTRUCTURE AND RESOURCES

The WHO (2018:22) states that infrastructure is one of the resources required to provide respectful maternity care during childbirth as it enhances the physical environment so that women and new-borns get clean bathing facilities, safe water for drinking, proper hand washing, as well as it facilitating birth companionship during labour. In a study done in Kenya, Afulani *et al.,* (2017:6) found that women's experiences were also influenced by health facility environment factors, such as cleanliness, the availability of water, clean bedding, and the sharing of beds. Women emphasised that for health facilities to be more appealing to them they wish to be in a home-like environment which is friendly and welcoming that also caters for their needs (Jenkins *et al.,* 2014:216). Women reported that the physical environment in the labour room influenced their fears as they could hear other women when in the labour ward (Larkin *et al.*, 2012:105). Furthermore, Bishanga *et al.,* (2019:11) mention that poor infrastructure is a barrier to birth companionship in Tanzania as the privacy of other women can be invaded. As a result, birth companions are only allowed to help with other tasks like collecting results, this does not fulfill the purpose and benefits of birth companionship.

On the other hand, some women reported high levels of congestion in healthcare facilities which leads to a delay in service provision and hampers the quality of care (Machira and Pulamuleni, 2018:30). This was also apparent in Jordan where women complained of congestion in health facilities as a result of poor infrastructure, women were sharing labour rooms and, as a result, their privacy was compromised. A systematic review of the determinates of women's satisfaction regarding maternal healthcare indicated that the availability of human resources influences women's perceptions about healthcare services across many developing countries (Srivastava *et al.*, 2015:6).

2.12 SUMMARY

In this literature review information was provided about the childbirth care services in Lesotho and the factors contributing to women's childbirth experiencers in other countries were identified. Quality care was identified as a major factor in the facilitation of women's satisfaction during childbirth. Influencing aspects of care, like continuous support, healthcare providers' attitudes, cultural sensitivity, and health facility infrastructure and resources, were found to have a significant impact on the perceptions and experiences of care by women. The next chapter presents the research methodology used to explore childbirth experiences in Lesotho.

CHAPTER 3:
RESEARCH METHODOLOGY

3.1 INTRODUCTION

Chapter three gives the in-depth discussion of the study methodology applied to explore women's childbirth experiences in two public hospitals in Lesotho.

3.2 RESEARCH AIM AND OBJECTIVES

The study aim is to explore women's childbirth experiences in two public hospitals in Lesotho.

The study objectives are to:

- Identify the negative and/or positive childbirth practices or services that can influence women's experiences in childbirth.
- Describe women's experiences in relation to the support given to them during childbirth.
- Identify women's experiences about the healthcare provider's attitude during their childbirth.
- Identify if women's childbirth needs were met.

3.3 RESEARCH SETTING

The study was conducted in two public district hospitals in Lesotho. The country has three regions: the northern, southern and central regions. The study was done in two public districts hospitals, one in the northern and one in the southern regions. The hospitals' names were not stated in order to protect the women' information as some of the information could identify the women. The district hospitals operate in twenty-four hours and provide childbirth services that include emergency care and management. The average number of deliveries per month ranges between hundred to one hundred and fifty deliveries per month. Maternity ward has 21 beds in both hospitals. The normal childbirth care is primarily provided by midwives, and doctors attend to complicated cases. The interviews were conducted in the maternal and child health unit with women coming for services on scheduled days and in separate rooms which were not used frequently by providers.

3.4 RESEARCH DESIGN

Research design forms the structural framework that helps the researcher to plan the study methods and design decisions (Botma, Greeff, Mulaudzi & Wright, 2010:108). A qualitative research approach was applied as it describes situations and experiences from the involved

people's perceptive (Grove, Burns & Gray, 2015:67). A qualitative descriptive design was applied to describe women's childbirth experiences in two public hospitals in Lesotho. The approach gives comprehensive information or experiences about the event or phenomena without detailed interpretations (Botma *et al*., 2010:194).

3.5 POPULATION AND SAMPLING

The population of the study was all adult women who have delivered in public hospitals in Lesotho, as they are the focus of the study (Grove *et al*., 2015:46). It was impossible to gain access to the entire population therefore a subset of the population which was accessible to the researcher was used, and this target population was women who have delivered in two participating public hospitals in Lesotho (Brink *et al*., 2012:131).

Sampling is the process of selecting women who will represent the population under study (Brink *et al*., 2012:132). Purposive sampling was used to choose participants from the accessible target population. The researcher performed a deliberate selection of the study participants who can give their views or experiences about the phenomenon under study (Brink *et al*., 2012:141). Grove *et al*. (2015:270) further explain that with purposive sampling the researcher may include typical or atypical, similar or varied situations with the purpose of obtaining rich data. The researcher ensured that the sample had similar characteristics to the population in order to achieve a good representation thereof (Brink *et al*., 2012:133). Demographic data such as age, gender, educational level, marital status, ethnicity and income level are commonly used in sampling as they influence the study variables (Brink *et al*., 2012:133). In this study women of different age, parity, and educational levels were purposively chosen from the accessible population to achieve varied women's childbirth experiences. About 25 per cent of the participants had a basic primary education level, 25 per cent had secondary education, while 42 per cent had high school level and 8 per cent a tertiary level education. The sample size in this qualitative study was dependent on the quality of data, while the number of participants was determined by data saturation (Grove *et al.,* 2015:274). Data saturation is when no new information emerges from subsequent interview during data collection (Brink, 2012:140). The researcher had planned to interview a total of sixteen participants, however only twelve women were interviewed as data saturation was reached.

3.5.1 Inclusion criteria

According to Grove *et al*. (2015:251), inclusion criteria is described as the main characteristics that the participants must have in order to be part of the target population. For this study the criteria for participants to be included were as follows:

- Women who were 18 years and older and had delivered at the participating public hospitals.
- Women who had delivered in a public hospital in a period of six weeks prior to the interviews.

3.5.2 Exclusion criteria

Exclusion criteria involved women with any condition that prevented them from participating meaningfully, such as women who were diagnosed with psychological conditions such as depression as the disease process can affect their judgment. Women who have come for their six weeks' postnatal service but had not delivered in the participating hospitals were also excluded (Grove *et al*., 2015:251).

3.6 DATA COLLECTION TOOL

In this qualitative study the researcher was interested in people's thoughts, feelings, ideas, experiences and perceptions and therefore data collection was done through interviews (Grove *et al*., 2015:83). The participant views, experiences and perceptions were collected through use of semi structured interview guide (De Vos, Strydom, Fouché & Delport, 2011:351). The interview guide was written in two languages that are official in Lesotho, English and Sesotho. Participants were allowed to choose their preferred language, however all participants chose to be interviewed in Sesotho.

The interview guide was divided in two sections. Section one inquired about the demographic information of the participant which included age, parity and level of education. Section two inquired about women's childbirth experiences in the public hospitals in Lesotho. In a descriptive qualitative study, the interview questions are aligned to the objectives in order to achieve the study purpose (Grove *et al*., 2015:251). Furthermore, questions were neutral and open-ended to allow participants to express their views freely (De Vos *et al.,* 2011:351).

The interview guide had four main questions and additional probing questions which were asked in order to explore women's childbirth experiences in public hospitals (see Appendix 1). De Vos *et al.*, (2011:352) explain that the interview questions can be arranged from simple to complex or general to specific to allow participants to adjust to the process. The following introductory question that was more general was used at the beginning of the interview to make participants feel more comfortable, "Can you please tell me about your childbirth experience in a public

hospital?" The following questions were more specific where participants gave their experiences on the support and attitude of the healthcare providers and their childbirth needs.

3.7 PILOT INTERVIEW

The small-scale interviews were done with two participants who possessed similar characteristics, as stipulated by the inclusion criteria of the study, with the purpose of assessing the design and data collection tool and making modifications if required (De Vos *et al*., 2011:394). The pilot interview was conducted in hospital A and inclusion criteria were ensured. The researcher used the interview guide for data collection. Participants were shallow in the expression of their experiences and the interviews lasted for about eight minutes. Brink *et al.* (2012:175) indicate that the pilot interview assists the researcher to make modifications to the data collection instrument or the study design. Therefore probing questions were added to the semi-structured interview questions in order to seek more expression of the women's experiences. The results are not included in study findings as there was limited information.

3.8 SCIENTIFIC RIGOR OF THE STUDY

In this qualitative study data quality or rigor was ensured through a model of trustworthiness, and the criteria include credibility, dependability, conformability and transferability (Brink *et al*., 2012:172). The four trustworthiness criteria will be discussed below.

3.8.1 Credibility

Credibility refers to confidence that the researcher has produced results that are a true reflection of the participants' experiences (Grove *et al*., 2015:392). Credibility ensured that the interviews were conducted in a way that reflected and interpreted the participants' views (De Vos *et al.*, 2011:419). The researcher gave reflection during data collection and asked probing questions for clarity in order to assess if the interpretation reflected the participants' experiences (Polit & Beck, 2012:564). The participants confirmed that the information reflected their experiences. Member checking was also done with participants to clarify the information that they had expressed with the purpose of accessing their intensions, correct misinterpreted data or give additional information. The researcher also provided interpretation feedback to participants to obtain their response and to confirm interpretation (Brink *et al*., 2012:172).

3.8.2 Transferability

Transferability implies the ability to apply the study results to different settings or to generalise the results (Brink *et al*., 2012:172). The researcher has provided detailed descriptions of data to

enable the reader to draw conclusions about their applicability in other contexts (Polit & Beck, 2012:560). Brink *et al*. (2012:172) explain some of the strategies that ensure transferability as being the detailed description of the study methodology, purposive sampling and data saturation. In this study detailed information was given about the study methodology; purposive sampling was done to choose participants with different variables in order to give varied experiences. Data collection was done until no new information emerged from the subsequent interviews. The researcher has kept the records and formulated memos during coding and data analysis process on how themes emerged.

3.8.3 Dependability

Polit and Beck (2012:559) explain dependability as the ability of the study findings to remain the same, if the study were to be repeated with similar participants in the similar context. Dependability was achieved by giving detailed descriptions of how the researcher collected data, the interview guide that was used and detailed descriptions of the research methodology. The study supervisor verified the study methodology, data collection instrument/interview guide and data analysis method.

3.8.4 Conformability

Conformability refers to the measures that are taken to ensure the truthfulness of the data and that it represents the participants' information and is without the researcher's bias, own perceptions or thinking (Brink *et al*., 2012:172). Furthermore, Botma *et al*. (2010:232) emphasise the importance of neutrality during the research process and the interpretation of the results to exclude biasness. Confirmability was ensured by noting and bracketing preconceived ideas to prevent any influence on the data. Moreover the researcher's supervisor reviewed the coded transcripts, results and interpretations in order to exclude the researcher's subjectivity or perceptions.

3.9 DATA COLLECTION

Women who had similar characteristic as of the study populations were recruited at six weeks post-natal clinic. The aim and purpose of the study were explained to the women and they were informed that their participation is voluntary; they can either choose to participate of decline participation. The midwife who was working in post natal clinic referred women who agreed to take part in the study and they signed consent for referral to the researcher. The interviews were held in separate rooms which were not frequently used by healthcare workers. The environment was conducive for the interview session as there was no noise, participants were made

comfortable so that they could be free (De Vos *et al*., 2011:350). The setting arrangement allowed for proper interaction and participation as the researcher and participants were seated facing each other with the table at the side rather that in between (De Vos *et al*., 2011:350).

The study information leaflet and the consent forms were discussed with the participants prior to commencement of the interviews. Women who agreed to take part signed the consent form. Women who gave consent were given a chance to choose to be interviewed at their preferred place either at home or at the hospital, and all 12 women chose to be interviewed at the hospital premises. Interviews started with questions about the demographic information so that women were made comfortable to allay anxiety. Participants were informed that the interviews would be recorded and they were assured confidentiality and privacy pertaining to the information that they shared. Participants and hospitals names were not used but were referred to as participant 1, hospital A.

An audio tape recorder was used to record interviews. The interview sessions was guided by use of semi structured interview tool. Field notes were written after the session to document important information or observations (De Vos *et al*., 2011:359). There are two official languages in Lesotho which are Sesotho and English. The researcher is fluent in both languages so participants were allowed to choose their preferred language for conduct the interviews. All the 12 participants preferred to be interviewed in Sesotho so that they could express themselves fully. Five women were interviewed in hospital A and seven were interviewed in hospital B. The interviews were done within two weeks of women coming for post-natal care. Two visits were done to each hospital and about three to four women were interviewed per day.

3.10 DATA ANALYSIS

Data analysis is the process of organising and structuring data to give it meaning (Polit & Beck, 2012:530). In this study data was analysed through the six phases of thematic analysis which help in identifying, organising and analysing a set of patterns in narrative qualitative data (Braun & Clarke, 2012:57).

3.10.1 Phase one: Familiarisation with data

During this phase the researcher listened to the audio tapes more than once, read through the transcripts several times in order to be immersed in the data, and also made notes on the data while reading the transcripts (Braun & Clarke, 2012:60). The capturing of data helped the researcher to analyse and critique the data to understand what it meant. The aim of this phase

was for the researcher to become familiar with the data set content which were prominent, and which answered the research question (Braun & Clarke, 2012:60).

3.10.2 Phase two: Generating initial codes

Generating initial codes started with labelling of the parts of data that answered the research question. Codes can be a summary of data or can describe the meaning of the data. The researcher had a mixture of descriptive and interpretive codes, which means that some codes describe the data while some interpret the meaning of the data. Thematic analysis is flexible as it does not indicate how many codes per paragraph but rather it emphasises identifying important information which might be answering the research question (Braun & Clarke, 2012:61).

3.10.3 Phase three: Searching for themes

This phase was aimed at reviewing the extracted codes from the data and identifying the meaning each code conveyed, identifying similarities and differentiating between codes. Codes were clustered to formulate themes in order to portray a more coherent meaningful description of the data (Braun & Clarke, 2012:63).

3.10.4 Phase four: Reviewing potential themes

The revision of themes alludes to quality checking and extracting the most important and relevant data that answers the research question. It involved the reading and reviewing of the themes against the codes in the scripts to ensure that the themes were consistent and aligned with the particular extracted data set. Where there were discrepancies in the connection of codes and themes the researcher discarded, relocated the codes or changed the codes (Braun & Clarke, 2012:65).

3.10.5 Phase five: Defining and naming themes

This phase gives clear description to the themes and differentiation between them. The criteria used for formulating coherent themes involved accurate interpretation of data and avoiding over-use of words. This phase involved critical structuring of the analysis; there was selection and extraction of data under each theme to give a clear story about the data (Braun & Clarke, 2012:66). The extracts were made across the data items to emphasise coverage of the theme. Data was interpreted and narration made to connect the interpretation to the extracts (Braun & Clarke, 2012:66). For example; similar codes were clustered together that either had meaning of timely access or delayed access to services and the theme was named response to need for care.

There were different experiences from participants where some had been attended on time while some believed that they were denied timely services.

3.10.6 Phase six: Writing a report

This phase began with note-taking that was done to highlight important information, and also involved previous stages of data analysis. The purpose of report writing was to explain the story about the data based on analysis. The researcher made a clear connection to the themes in order to tell a more meaningful story (Braun and Clarke, 2012:66). Chapter 4 elaborates on the findings from the analysis.

3.11 SUMMARY

Chapter three gave a detailed description of the study methodology. The research design, approach and data collection process was discussed. Data analysis was applied using the six steps of thematic analysis, which were explained. Trustworthiness was discussed to ensure validity of the findings.

3.12 CONCLUSION

The research methodology used was appropriate for the study as women gave their different individual experiences. A qualitative approach enabled the narration of the experience in order to give a clear understanding of individual childbirth experiences. The data analysis method was very helpful as it gave clear guidance on step by step narrative data analysis. The study findings and interpretation will be discussed in the next chapter.

CHAPTER 4:
DATA ANALYSIS AND INTERPRETATION

4.1 INTRODUCTION

This chapter gives a description of the data analysis and findings regarding the interpretation of women's childbirth experiences in public hospitals in Lesotho. Verbatim transcripts were used to capture participants' views and experiences and this facilitated the decoding of behaviour and cultural meaning attached to their perceptions (Grove *et al*., 2015:88). Data analysis was conducted as per the six steps of thematic analysis elaborated by Braun and Clark (2012:60). The study findings are discussed in two sections. First section presents the demographic details of the participants which includes age, parity and educational level. Second section presents themes and subthemes that emerged during data analysis.

4.2 SECTION A: BIOGRAPHIC DATA

Demographic data gives a brief overview of the characteristics of the participants. Twelve women who had delivered in the participating hospitals were interviewed.

Table 4.1: Biographic data of the participants

Hospital Code	Participant id	Age	Parity	Marital Status	Education standard
A	1	32	1	Single	University degree
A	2	27	3	Married	Standard 10
A	3	20	1	Married	12
A	4	25	2	Married	7
A	5	28	2	Married	10
B	1	26	1	Married	12
B	2	30	4	Married	4
B	3	24	1	Married	12
B	4	21	2	Married	12
B	5	29	3	Married	7
B	6	25	3	Married	12
B	7	41	2	Married	10

4.2.1 Age

The inclusion criterion for the study was adult women who have delivered in public hospitals in Lesotho. Recruitment of participants was done at the adult women's post-natal clinic, where women of 18 years and above were approached. Participants' ages ranged between 20 to 41 years. Six study participants were between 20 to 26 years while six were between 27 and 41 years.

4.2.2 Parity

Participants' parity ranged from one child to four children. Of the twelve participants, four had one child, four participants had two children, three participants had three children and one participant had four children. According to the Lesotho Demographic Health Survey (2014:72) in Lesotho the total fertility rate per woman is 3.3 children and fertility peaks between ages of 20-24 and then declines steadily thereafter.

4.2.3 Education level

The educational level of the participants ranged from standard 4 to tertiary degree. Three participants had an educational level of standard 4 to standard 7 (Primary education level), while three participants had an educational level of standard 8 to standard 10 (secondary education level). Five participants had an educational level of standard 11 to standard 12 (high school level) and one had tertiary level education. This data is in line with the Lesotho Demographic Health Survey results which indicate that women with primary education have an average of 1.6 more children than women with higher education (Ministry of Health, (LDHS), 2014:72).

4.3 SECTION B: EMERGING THEMES AND SUB-THEMES FROM THE DATA

Data was analysed and the following six themes and 20 sub-themes emerged, and they are presented in Table 4.1. The interpretation of data is given to describe the meaning of the quotes. The participants' verbatim statements are quoted in the discussion of the sub-theme to give evidence to participants' own words. The quotes are shown in *italics.* The themes and sub-themes are categorised under the objectives of the study.

Table 4.2: Themes and sub-themes that emerged are tabulated under the study objectives

Objectives	Themes	Sub-themes
4.3.1 Identify negative or positive childbirth practices or services that can influence women's experiences of childbirth	1. Women' experience about the childbirth services or practices	1. Positive experiences regarding childbirth practices
		2. Negative experiences regarding childbirth practices
		3.Satisfactory services
		4.Dissatisfactory services
4.3.2 Describe women's experiences in relation to support given during childbirth	2. Support	5. Healthcare provider support
		6. Family support
		7. Clinical support
		8. Lack of support and feeling of abandonment
4.3.3 Identify women's experiences regarding their healthcare provider's attitude during their childbirth	3. Provider attitude and communication	9. Positive provider attitude
		10. Negative provider attitude
		11. Effective communication and a trusting relationship
4.3.4 Identify if women's childbirth needs were met	4. Woman's need for care	12.Timely care
		13. Delayed care
		14.Being in wrong health facility
	5. Woman's involvement in care	15. Informed care
		16. Lack of information regarding care
		17.Coersed care
	6. Maternity ward environment and resources	18.Physical environment
		19.Availability of material resources
		20. Availability of human resources

4.3.1 Objective 1: Identify positive and negative childbirth practices or services that can influence women's experience of childbirth

4.3.1.1 Theme 1: Women' experiences on childbirth practices or services

Childbirth experience is associated with many factors that include women's expectations about their birthing, the services rendered, information sharing and communication (Henriksen, Grimsrud, Schei and Lukasse, 2017:33). The general service, care and practices that women encounter during childbirth have an impact on their experiences. The findings demonstrated positive and negative clinical practices and hospital norms that influenced how women experienced their care. Moreover some participants gave a general view on their childbirth experience. Experiences of participants with regard to the practices or services delivered during

childbirth differed between individual participants. The theme looked into the participants' perception on the healthcare practices during childbirth and general experience of care. The critical aspects being the childbirth practices, procedures or hospital-based norms as well as their general view of the entire childbirth process experience.

a) Positive experiences regarding childbirth practices

Positive childbirth experiences were described where hospital practices were not in conflict with participants' choices, expectations or values. The practices in hospitals differ from hospital to hospital, and women experience services based on their expectations, their prior knowledge, or the previous experiences of people close to them. Placenta disposal practice is done based on hospital policy. Some hospitals allow women to decide on whether they want the placenta to be disposed at the hospital or they want to take it home. A participant described her concern with regard to placenta disposal, however some women may have a concern when they are not given a choice. If incineration is done according to the hospital's policy, it may cause some problems for the individual when this practice is against their cultural practices as in some cultures the placenta is taken home after delivery. The open placenta disposal policy influenced the participant experiences positively.

> *"I asked the midwife about the placenta if new mothers are allowed to take it home. She told me that after the baby was born, if you want to take it you can take it. If you don't want it, it is thrown away"* (P 6 hospital B).

Post-caesarean care may also differ within various hospitals where in some hospitals women are given their babies after anaesthesia has worn off, and in other hospitals women express their readiness to be given their babies. The findings describe a positive experience as one participant appreciated the practice of allowing women to be physically and emotionally ready to hold and bond with the baby.

> *I was approached and told that I would not get the baby immediately…I should rest first. I was given that time to rest first. The baby would come after I had rested…my emotions were found- that I was okay; I could hold the baby* (P 1 Hospital A).

b) Negative experiences regarding childbirth practices

Some practices were expressed as negative due to the impact they had on the participants. In circumstances where services were associated with pain and discomfort women perceived the practice or service as negative. Participants revealed their experiences with regard to practices

that were offered during childbirth. Suturing of the perineum is a practice done to align the anatomical structures after the birth of the child; one woman reported poor pain management and experience of severe pain. Participants also expressed negative experiences due to vaginal examination procedures which were done to monitor cervical dilatation. They also found it to be very uncomfortable.

> *"Like when they check you. That issue of fingers being inserted. Honestly, I found it to be something so painful"* (P 1 Hospital B).

> *"Ah, the stiches were painful …. So, she said she was going to stitch while I could feel it due to my high blood pressure"* (P4 Hospital B).

c) Satisfaction about services delivered

A number of participants expressed words of gratitude for the services they received and they gave a general view of their perception of their experienced care. The perception of good services was linked to a general perception of care. One participant appreciated the services that were offered by the healthcare provider and indicated that she would use the facility in the future.

> *"Honestly, I don't want to tell a lie. I found the strength of coming to talk…because I came to give the people who assisted me the honour. They helped me with all their heart because I was…I was giving them trouble but the woman who was helping me was able to have patience until I was through"* (P 3 Hospital A).

d) Dissatisfaction about services delivered

Not all participants were satisfied with the services. Some participants reported dissatisfaction with the services that were provided. Dissatisfaction was linked to factors such as how they were welcomed into the maternity ward on admission and poor pain management. One woman was sutured without local anaesthesia to reduce the pain and was not happy with how she was sutured.

> *"The time when I was cut down there so that the baby's head is able to come out and be born without having a problem there on the head or wounds- I was not injected then. I was just sewn without anything been done so that you don't feel pain at all. I was not properly stitched"* (P 6 Hospital B).

Another concern which lead to a perception of dissatisfaction about the general care during childbirth was a delay in the provision of care. A poor relationship of trust was evident as the provider ignored the participant's complaints or reports.

> "*Yes… When you try to shout, when a person arrives, she comes dragging her feet. This baby…I nearly delivered him by myself*" (P 2 Hospital A).

Perceptions of a good service provision was linked to the provider's capabilities to share information about the services rendered to women, while dissatisfaction was observed where women' needs were not taken into account, there was a lack of competency by providers and a poor relationship of trust between the woman and the provider.

4.3.2 Objective: Describe women's experience in relation to support given during childbirth

4.3.2.1 Theme 2: Supportive care

The benefits of continuous support during childbirth are widely indicated from different settings globally as evidenced by literature, however different constraints have been identified with regard to implementation, and such include advances in medical technology, shortage of midwives and absence of doulas in some facilities (Lunda *et al*., 2018:1). The study objective was to describe childbirth support from Basotho women's perspectives.

Support during labour was described based on aspects of care that included physical presence, emotional assurance and information sharing, and doing clinical procedures. Participants had differing perspectives where some were appreciative of the support that was given by healthcare providers during labour, while other participants indicated that the nurse's duty is mainly to monitor the progress of labour therefore nurses are not able to offer the needed support. Some participants indicated that they would appreciate it if the public hospitals could allow the presence of family members or partners during labour.

Contrary to the mention of different support structures, some participants did not experience any type of support and they felt abandoned. There were suggestions that family support could be effective during childbirth and this is in line with literature discussed in chapter 2, section 2.8.1.

a) Healthcare provider support

Healthcare provider support was expressed whereby participants acknowledged the assistance and support they received from providers either through the intervention where they were

massaged, or with providers being physically close to them, or through information sharing to empower the women.

> *"Well, I was satisfied by the way in which they treated us. Honestly when the contractions were there, there were people who came and massaged us"* (P3 Hospital B).

Physical presence of healthcare providers was valued as participants felt they were under good care. Participants expressed their fears and were advised accordingly.

> *"…they sat next to me. They were able to have patience when I said it was painful somewhere…and they said 'uh-uh, do this thing'. And even myself…in the end I ended up not being troublesome. When they said I should do this, I was able to do it, because I even ended up having their strength"* (P3 Hospital A).

Participants indicated that they were supported well by healthcare providers as they showed concern by asking questions to give them the needed support. Only a few participants identified midwives as a support structure during labour, while the majority indicated that midwives have many duties which make them inappropriate personnel to offer support during labour.

b) Family support

Although family support was not experienced by all participants, some participants expressed the need for family support during labour and indicated its benefits to women. Benefits included: comfort, companionship and reassurance that all will be well. The participants described the importance of the presence of a family member during labour as nurses have to take care of many women and are unable to be constantly close to women.

> *"…it's like these public hospitals of ours could let our parents be with us in the ward there where we are going to give birth at. The presence of our parents or of our partners- that is, I think it can make us to be comfortable. Like for you to see that you are not alone because when you are in there, really you think many things. You don't know what is going to happen to you or the baby"* (P 2 Hospital B).

One participant emphasised the importance of family support during labour and indicated that healthcare providers should have empathy for women and treat them as if they were their own relatives.

> *"Sometimes when I am sitting by myself…I do wish that nurses could be biological siblings…they should empathise with people. That is, you will be trying to hide the pain, but it will not be possible and then there are some nurses who lose patience"* (P 3 Hospital A).

c) Clinical support

Some participants described support as the midwives' efforts to ensure a positive labour outcome. According to participants, midwives' knowledge pertaining to childbirth, clinical assistance through interventions and procedures such as blood pressure check were regarded as support. Participants indicated that without the midwives' assistance, complications may have arisen.

> *"I saw that we were with people who took care of us…who followed us and kept on checking for high blood pressure- how it was…how the wound was…if I didn't come here to the hospital and say maybe, I said I would deliver at home- you see I would have had a problem if the cervix wasn't opening. They have helped me with their knowledge"* (P 7 hospital B).

Continuous support was described depending on participants' preferences. However, across all the sub-themes women appreciated the nurses' support by being physically there, massaging them, sharing information and assistance when they were unable to perform certain tasks like climbing onto the delivery bed. Family support was also highlighted as an important aspect as it brings comfort and allays anxiety. Clinical support was valued as nurses are knowledgeable about childbirth and are able to prevent complications which may otherwise have occurred if they delivered at home. However, for most participants midwives are not an appropriate structure to offer continuous support due to the nature of their work. They have to care for many women and they have other responsibilities.

d) Lack of support and feelings of abandonment

Some participants experienced a feeling of loneliness and being unsupported. They wished for an individualised care which was responsive to their requests. Participants indicated that they were left alone and were not instructed on what to do when they needed help and this brought forward feelings of abandonment.

> *"It's like there could be someone who could be supporting you- next to you or at the time when you say 'oh no! I need certain assistance, they should be able to hurry up and do so"* (P 4 Hospital A).

> *"After I had gotten up on the bed, they injected my right thigh and I remained in there. They got out and left me in the labour room"* (P 5 hospital B).

One participant further indicated that the nurses' duty is mainly to ensure that the baby is born in a healthy state and highlighted that after delivery the healthcare providers give more attention to the baby while mothers are left unattended.

> *"So, then the nurses- their main job is to see to it that I get the baby out. Even when she is supporting you like that, but their main job is to see to it that the baby is healthy and well…because even when the baby first comes out, it is taken and put there…they focus on the baby right? While yourself you are on the bed"* (P 2 Hospital B).

Support was regarded as an important aspect of quality care, even though midwives were regarded as a support structure most participants believed that they have to care for more than one woman and have other responsibilities and are therefore not the best support structure. None of the participants experienced family support and some of them indicated that public hospitals should consider its implementation.

4.3.3 Objective 3: Identify women's experiences about the healthcare provider's attitude during childbirth

4.3.3.1 Theme 3: Healthcare provider's attitude and communication

Healthcare provider attitude was identified as one of the factors that affect quality care, as women highlighted that they value their provider's personal characteristics as much as they value their competency (Jenkins *et al*., 2017:216). Furthermore the International Confederation of Midwives (ICM) philosophy indicates that, "midwifery care takes place in partnership with women, recognising the rights to self-determination, and is respectful, personalised, continuous and non-authoritarian (ICM philosophy of midwifery care, 2014). The goal of the study was to assess midwives' respect towards women and identify nurse–patient communication.

Humans are social beings, the way someone portrays themselves or communicates to them affects their perception of the services they offer. The healthcare providers' attitude played a critical role in how participants described their childbirth experience. Although participants mentioned that they were in pain and sometimes doing what was not expected of them they still wished to be in warm hands and be helped by people who understood their situation. The healthcare provider's attitude was described from different perspectives, where some women

experienced a positive provider attitude that made them appreciate the provider's efforts. However, some described a negative attitude that made them question their choice of healthcare facility.

a) Positive provider attitudes

Participants described their interaction with providers as welcoming; they felt at home and considered providers as their sisters who showed empathy towards them. The following quotes indicated good care where participants felt well cared for by people who are welcoming and who portrayed a positive attitude.

> *"…they were able to speak to us in a way that…similar to that of a sister to a sister. It wasn't harsh…like they didn't scold- they didn't make noise for us"* (P1 Hospital A).

A positive provider attitude was further described based on provider openness and how they interacted with women.

> *"Honestly, those women- I saw them to be people who were happy, who talked to people. They were not people who had tightened their faces. They didn't scold- they were nice people"* (P 7 Hospital B).

In conclusion, a positive attitude was mainly described based on the interaction between the provider and woman, openness and respect for women by accommodating their views and building a good relationship of trust.

b) Negative provider attitudes

Even though some participants appreciated the kind of childbirth care they were offered and the good attitude they experienced from providers, some participants mentioned that they had experienced bad attitudes from healthcare providers. The bad attitude was mainly associated with midwives' ability to scold, make noise and not really take participants concerns or reports into consideration.

> *"Well, she wasn't talking to us nicely. She was shouting…she was scolding us… sometimes when you called her to come and help you, she would come after some time"* (P 5 Hospital B).

Participants considered midwives as professionals who are trained in the childbirth process and who should show patience towards them. However, the findings identified a midwife's intolerance

and level of unprofessionalism whereby a provider crossed the anger level expected of her by the participant. The participant acknowledged that the provider did not have the skills to help someone in labour however, she believes that providers need to be trained on how to help women in labour as they were impatient.

> *"Hey! This woman of number 2… the one who helped me…number 2…its true as people we can't…it could be that we were doing things that she didn't like because I don't know how to help someone to deliver. But she should try to talk nicely to people. Yes. She had crossed the line when she became angry. I don't know which kind of training they could have but they need it"* (P1 Hospital B).

One participant described a negative attitude; however she indicated that she may have provoked the provider to behave the way she did. She indicated that sometimes providers scold in order to prevent danger to women, as in her case she may have delivered while on the floor.

> *"I didn't feel like she scolded me wrongfully because it was me who was making a mistake in that if I didn't get up right then, it could happen that the baby gets born while I'm still on the floor and that wouldn't be her fault because it had been a while since she said I should get up on it. It would be mine"* (P 4 Hospital B).

A negative provider attitude was highlighted by women revealing their negative experiences when providers scolded or showed anger towards them. They further explained that providers should be trained to provide good services.

c) Effective communication and a trusting relationship

Communication serves as an important aspect of quality healthcare provision. The WHO (2016:22) indicates that effective communication improves the relationship between the healthcare provider and the woman, and leads to positive childbirth experiences as it reduces anxiety. Participants had different experiences about the communication between them and their providers during childbirth. Effective communication was experienced by some participants who expressed their appreciation about communication that prevailed between them and their healthcare providers. There were mentions of the manner of talking, the information giving process and also giving the woman details of their care why a certain procedure is being done, why certain behaviour was discouraged during labour and also what the consequences may be or the `implication of certain acts to the mother or baby.

> *"It was the attendance of the nurses…the way they communicated in. The way they were talking to each other, helping each other…like if there was a problem… I was well cared for. Even communication between myself and them…they responded to me on time…they didn't get angry at me. They were nice to me"* (P1 Hospital A).

> *"She told me that I shouldn't push before the time of pushing arrived because I would align the baby with the bones and the baby will be born with an injury like on the head"* (P 2 Hospital B).

Participants acknowledged the efforts of healthcare providers who communicated detailed information which made them feel empowered and satisfied with the services offered.

> *"The nurse told me how I should put the cotton wool…showed me how to breastfeed the baby. She said I should not put the baby on a pillow when I am sleeping with him. I should keep on changing its sides…I shouldn't let him sleep on one side"* (P 6 hospital B).

Effective communication is crucial in maternal and child health as it facilitates a good trusting relationship between women and providers. Findings revealed that good a midwife-woman relationship which showed trust.

> *"'How many people are going to help me in here?' and then he explained to me that 'no, these women that you see here next to your head are the ones who are going to help you' And then I said, 'no, I don't feel like I need only them. I feel like I need that woman I came with here- who brought me to the theatre. I feel like she should come and stand next to me while I am being assisted'* (P 4 Hospital A).

Communication was described by participants as the ability of providers to talk or describe the steps of care so that women are aware of the childbirth process. Effective communications lead to good trusting relationships between the participants and the midwives. There was also a health education aspect which empowered the participants.

4.3.4 Objective 4: Identify if women's childbirth needs were met

4.3.4.1 Theme 4: Woman's need for care

Most women hope for a birth experience that takes into account their physical, psychological as well as cultural needs through support, involvement in care and assistance by sensitive providers who create a psychologically safe environment (Downe, Finlayson, Oladapo, Bonet and

Gulmezoglu, 2018:6). Therefore the study goal was to identify the aspects of care that women needed or expected and were offered, and also to identify the gaps thereof. Participants had an expectation of being attended to immediately when they arrived at the maternity facility as they had reported signs of labour. However healthcare providers' responses to women's need for care or urgency of treatment varied. The findings revealed that some participants were given timely care, treatment and referral while some were denied services on time which led to complications. Choice of healthcare facility may be influenced by women's needs and expectations; however some participants regretted their choice and regarded themselves to be in the wrong place which does not respond to their needs

a) Timely care

Timely management is very important in midwifery as delay can contribute to serious maternal or newborn complications. Moreover timely management gives women a sense of fulfilment and feeling that they are under good responsive care. Some participants indicated that they were given timely care, and that there was a good attendance on admission, and there was also responsive care to the women' reports.

> *"Ok. When I arrived …I was assisted by two female nurses. They attended me at once – at that time…they checked me as I was already having strong contractions, they discovered that it was like the doctors were needed immediately. They communicated with the doctors and from there I was taken to theatre"* (P 1 Hospital A).

> *"I saw that at the time when…like for example, when I said that I was in pain, I was attended on time"* (P 1 Hospital B).

b) Delayed care

Contrary to the timely care, some participants reported delays in the response to their care, where they felt ignored and providers took too long to offer services to them. The participants indicated delayed attendance by nurses as well as doctors.

> *"It was around past 4… past 4. Yes. I arrived and went via the reception and I ended up just sitting there, I was not assisted. Honestly. Much later another person came…, she came to me …I even heard them talking that side. That other one said 'Uh-uh, you know someone may even give birth still sitting like this without being attended'* (P 2 Hospital A).

> *"Well the services, I can complain that when I arrived the doctor delayed to see me. Yes madam. That is the thing which I could complain about. I sat for a long time in there without the doctor checking me"* (P 4 Hospital A).

c) Being in a wrong health facility

One participant experienced poor services and questioned her choice of a healthcare facility as it did not respond to her needs. This participant received bad treatment as opposed to the quality care she wished to receive when she made her choice of heath facility.

> *"… I delivered my baby at night. Really the night-duty nurses didn't treat us well. Mm, I am not satisfied. Yes ma'am. Well, I felt very insignificant you know. I even asked myself why I have come to this hospital"* (P 2 Hospital A).

A few participants experienced the care when they needed it, however for most participants provider response to their needs was not as they had expected; there was reluctancy and neglect in provision of services.

4.3.4.2 Theme 5: Woman's involvement in care

The theme woman's involvement in care emanated from providers' ability to share detailed information with women regarding their care and women felt empowered. On the contrary other findings revealed uninformed care, lack of information and mistreatment where a participant was coerced into care with no information as to why she was given the type of care and given a chance to give her own opinion on the care.

a) Informed care

Information given about services rendered helped women to understand their care and the implication of the services. Good communication was seen by the previous quotes where women felt empowered through information sharing or clarification of the steps in their provision of care. Some quotes were more informative in terms of explaining why the care was offered and the implication of either undertaking the suggested intervention or not, and there was a level of involvement where women had a say regarding their care. The following quote explains why certain interventions were done or not done.

> *"They said, 'we are going to inject you with these injections so that you don't feel pain'. Well, they also inserted me the pressure cuff- as they were working they had put a*

> *pressure cuff and kept on checking blood pressure since I am someone who has high blood pressure"* (P 7 Hospital B).

Informed care was also prevalent where women were given education on what to expect during the labour process and the implications of certain actions to the childbirth outcome.

> *"She even said I should keep on breathing in the contractions if my waters had already broken or if there was something that I see I should tell her. I told her when i started seeing blood"* (P 6 Hospital B).

b) Lack of information regarding care

The sub-theme lack of information regarding care was described when women were not informed of their care. Some participants mentioned passive care where providers just carried on with their jobs without explanation as to what they were doing, why they were performing the required procedure or giving the findings of the examinations. The quote shows a lack of understanding as to what or why the providers performed certain actions.

> *"Before I went into waiting mothers- after they were done examining me, they said that I was still behind. Uh-uh. Honestly they didn't tell me how far I have progressed"* (P 5 Hospital B).

c) Coerced care

Coercive care is regarded as mistreatment in childbirth as it violates the woman's right to freedom of choice and decision making. One participant felt she was coerced or forced into care without her consent and she had to submit to what healthcare providers told her even though she did not understand the benefits or reasons.

> *"… I wasn't happy when we were forced to go to the waiting mother's shelter, yet we still had a way of coming back to the hospital. While I was still there in the waiting mother's room, he spoke like it was optional. I can choose whether I agree or I don't…I felt like he was forcing me that if I don't want to go there- meaning that I am refusing doctor's orders. But the first time he said it, it was like I had a choice"* (P 1 hospital B).

In summary, informed care was provided as well as education on childbirth and post-natal care. The implications of doing certain procedures which are dangerous to the health of the mother and the baby and which can bring about complications were discussed. On the contrary uninformed

care was associated with coercion into services and findings not being communicated to women in order for them to know their progress or why certain procedures were being done.

4.3.4.3 Theme 6: Maternity ward environment and resources

The hospital environment, such as the state of the maternity ward, also influenced women's experiences. These included factors such as room temperature, bedding and linen, and cleanliness of the equipment. The participants described the maternity environment as undesirable.

a) Physical environment

A hospital's physical environment should be conducive for women and their newborn babies. Aspects of care which are necessary for post-delivery management such as a warm environment for babies' thermoregulation and maintenance of cleanliness for infection prevention were hampered. Participants mentioned that they could not access safe water for drinking, they were using dirty linen and the ward temperature in maternity was cold.

> *"Well! I was taken to the room, but It didn't satisfy me because it was cold…it was cold…the heater in there doesn't work"* (P 2 Hospital B).

> *"…again, the dirtiness, these hospital beds… you will find out when you arrive that no, indeed they are dirty and there is Blood. They delay to change bedding honestly"* (P 2 Hospital A).

> *"Mess in the maternity ward. At the sink where we draw water that we drink…honestly, it wasn't nice. There was like some blood…so one was unable to draw water to drink"* (P4 Hospital B).

b) Availability of human resources

Human resource impacts the services in maternity as bed occupancy is unpredictable and complications may arise at any moment. Shortage of human resources was apparent to participants and it led to the occurrence of complications as midwives could not access help due to a shortage of assistants. There were concerns regarding the midwife-to-woman ratio.

> *"…we were being helped by one woman as many as we were. I think we were 10 or 9. The baby was already born, and she left me to go and take a look in there …it's called in the…at the female ward. She asked…she was looking for someone who could help her.*

> *The baby was already born but then there was nobody who came back…"* (P 5 Hospital A).

Shortage of staff, especially at night was experienced by some participants and they indicated that the shortage could lead to poor management of women post-delivery or could even put the babies' lives at risk.

> *"Sometimes you have high blood…after you have delivered it will have shot high right? It is there where she will be trembling on the bed, doing things which are not nice right? So, the female nurse is alone at that time. The baby also has to be clothed so that it doesn't get chill of that time when it will be born. So, honestly, I am requesting that nurses should be increased like at night"* (P 2 Hospital B).

c) Availability of material resources

Availability of material resources and equipment was mentioned by participants to be important. Participants mentioned that they were expected to bring blankets to the hospital because the hospital blankets are very light.

> *"Yes. Blankets- isn't it it's said that you should bring a blanket? You will have brought a blanket that you will be wearing right? Or you've wrapped around yourself. When you arrive in there the blankets are very light"* (P 2 Hospital B)

Participants also mentioned their concern whereby providers use equipment which is not up to date. A participant indicated concern in the use of a 'plastic thing' (Fetoscope) because she could not understand how a midwife was able listen to the heartbeat. Lack of understanding can cause mistrust and dissatisfaction with providers.

> *"We shouldn't be listened to with these plastic things…I didn't know what it's called. Isn't it it's just put like that? How they'll hear the heart? It's just that thing. She listens with the ear. That plastic thing … So how they end up hearing the heartbeat myself I don't know"* (P 2 Hospital B).

Women's needs were not met in childbirth due to in-conducive environment for mothers and babies in the wards and the shortage of healthcare providers such as doctors and midwives. The shortage has led to neglect and a poor quality of service provision. Participants were also not satisfied with the material resources and equipment used in public hospitals.

4.4 SUMMARY

In this chapter, the findings of women's childbirth experiences were discussed and the interpretation given. Themes that emerged include; women's experiences about the childbirth services or practices, support, provider attitudes, informed care, woman's need for care, and maternity ward environment and resources. In the next chapter findings will be discussed in relation to literature, and limitations and recommendations will also be discussed.

CHAPTER 5:
DISCUSSION, CONCLUSION AND RECOMMENDATIONS

5.1 INTRODUCTION

The previous chapter presented the findings of the study with supporting participants' verbatim quotes. In this chapter the findings will be discussed based on the objectives of the study and the literature. The recommendations will be given based on the study findings.

5.2 DISCUSSION OF FINDINGS

The aim of the study was to explore women's childbirth experiences in two public hospitals in Lesotho. The findings and how they relate to each objective will be outlined and the discussion will be supported by literature. Ilidou (2012:387) emphasised that personal expectations, continuous support, and effective communication that includes informed decision making, influence women's perceptions about their childbirth care. Therefore the aspects of quality care are aligned to the study objectives as discussed below.

5.2.1 Negative or positive childbirth practices or services that can influence women's childbirth experiences

In the past two decades there has been an increase in the childbirth practices during labour which are done with the intension of improving maternal and neonatal outcomes during labour and post-partum (WHO, 2018:1). A midwifery-led model of care is associated with more benefits for the mother and the baby and a positive childbirth experience due to less intervention during childbirth (ICM: online). The findings have identified positive and negative practices that influence women's childbirth experiences. Midwifery-led care emphasises normal childbirth with less interventions and practices to promote woman-centred care (Pazandeh *et al.,* 2017:63). Positive practices were mentioned as empathetic care versus neglect, and one participant experienced positive care when providers asked her to say when she would be ready to be given her baby post caesarean section. She felt better and was given her baby only when she was ready. Moreover participant choices were considered with regard to placenta disposal which influenced their childbirth experiences. Most women are attended to by midwives during antenatal, childbirth and post-natal care with exception of referred women presenting with risk factors. Even though Lesotho mainly operates on midwifery-led care which is associated with less or no interventions, findings have shown that some women reported dissatisfaction due to practices such as episiotomy cutting,

suturing and poor pain management. Women believed midwives were incompetent in performing the mentioned procedures.

Henriksen *et al.* (2017:34) indicate that the general perception of care is not related to the occurrence of adverse events or complications but really of the care and support that woman experienced during childbirth. The study findings have shown that the general perception of care regarding services done during childbirth were positive where some participants mentioned that they would use the same healthcare facilities in future. Nevertheless, from the same findings some participants reported negative childbirth experiences as they were constantly scolded to a point where they could not differentiate between right and wrong.

Lappeman and Swartz (2019:1) describe childbirth practices such as neglect, inappropriate use of medical interventions, emotional and physical abuse, lack of confidentiality and consensual care as problematic and indicate that they can affect women negatively. Neglect is apparent when healthcare providers ignore or do not listen to women situations, wishes and needs and attend to women on their own terms and fail to discuss or disclose results (Mukamurigo *et al.,* 2017:5). The study findings revealed that use of frequent vaginal examination was uncomfortable and caused pain for participants such that they wished there were other ways of monitoring cervical dilatation besides the vaginal examination.

In conclusion participants have experienced positive practices which made them feel comfortable as they were given a chance to give their opinion and verbalise their needs. A general perception of satisfaction was identified as participants rated their general opinion on services rendered. Healthcare provider patience and empathy to women was apparent. Practices that caused pain like episiotomy cutting, suturing without anaesthesia were regarded as negative hence they led to dissatisfaction.

5.2.2 Women's experiences in relation to support given during childbirth

The WHO (2016:23) has indicated that every woman should be given a birth companion of her choice during childbirth in order to facilitate a positive childbirth outcome. Benefits of continuous support during childbirth have been documented globally in literature. Hodnett, *et al*. (2014:3) mentioned that continuous support during labour facilitates good progress as it allays anxiety and fear. This was evident in the study results as some participants acknowledged support from the midwives and mentioned that midwives were constantly available to offer support, massaged them and women were able to express their fears and were reassured accordingly. The

participants who experienced healthcare provider support reported that they accomplished a positive labour outcome due to the support they were offered. Aune, *et al.* (2012:89) also emphasise that continuous midwifery support was associated with a good nurse-patient relationship, emotional support and spontaneous labour.

Even though the benefits of continuous support are widely documented there are challenges with regard to implementation, factors such as advanced and evolving healthcare systems which have introduced technology into childbirth care, midwives who are not able to offer continuous support to women as they have to take much of their time on technological monitoring (Lunda *et al.,* 2018:11). On the contrary, study results revealed that a few participants expressed the healthcare provider's efforts in monitoring and undertaking of clinical procedures as support. Participants also acknowledged the midwives' knowledge and assistance to deliver as support.

However, Hodnett *et al*. (2014:4) have found that midwives are unable to offer support during labour as they care for more than one woman during childbirth added to their responsibility of monitoring labour and completing documentation. Similarly, study results indicated that midwives are not able to give the best support as they have to care for many women. Participants mentioned that they wished for individualised care such that midwives are constantly near them to offer support as per their needs. Lunda *et al.* (2018:8) highlighted that lay support persons such as doulas or family members can be in a better position to offer support as opposed to midwives. Results proved the need for family members or partners' support during childbirth as these people know the women better. However, infrastructure was identified as one factor that hampers quality childbirth service provision in Lesotho (MDG status report, 2016:61).

Doula support and family member support is not implemented in public hospitals in Lesotho which therefore hampers effective continuous support to women during childbirth. This finding is in line with literature wherein Stankovic (2017:805) highlighted that in low-income countries other support structures like doulas or family support are not allowed as they can compromise privacy due to lack of infrastructure. Kozhimannil e*t al.* (2017:2) have shown that the results of randomised controlled trials done on different types of support given during childbirth has shown that doula support was associated with more benefits and women satisfaction than other types of support. However, this study's findings did not reveal this type of support due to the infrastructural challenges noted above.

In conclusion findings of the study revealed that support during childbirth was not maximally experienced by most participants as the only support structure they were able to access was the midwives' support which was proven in literature to be ineffective as compared to other support structures. Even though some participants acknowledged the clinical care such as monitoring, and execution of clinical procedure as support, some still felt they would want more in their care like the constant presence of someone to be close to them as they felt abandoned and alone during labour.

5.2.3 Women's experiences about healthcare provider attitudes during their childbirth

Women's satisfaction about childbirth services is mostly determined by midwives' behavior and attitude (Oosthuizen *et al.,* 2017:2). Literature reveals that a woman's choice of healthcare facility is influenced by healthcare provider attitude and drug availability (Bishanga *et al.,* 2019:2). The study's findings depicted a positive provider attitude where participants mentioned feeling respected in the way they were treated and communicated with, and they also mentioned the possibility of using the facility again in the future. The participants mentioned that they were not scolded but they were given the type of care that was similar to a sister to a sister indicating the bond that was apparent between women and midwives.

On the contrary, results have shown that some participants encountered midwives with bad attitudes as they were shouting and scolding women in labour. Participants reported that they were ignored and neglected when they reported intense labour pains and were not attended to on time. Participants particularly indicated that the night duty staff were rude and scolded them and they made a point that they believe midwives should be trained on how to empathise with women in labour as they were impatient to the women needs. Moreover, change of shifts between day and night staff was found to affect the continuity of care. Most women reported dissatisfaction with care given by night staff. Similar results were noted in Jordan, where participants mentioned that the change of shifts affected continuity of care and development of a trusting relationship between women and midwives (Hatamleh *et al.,* 2013:506).

Chadwick *et al.,* (2014:863) has shown that when midwives do not treat women with respect, women may delay seeking services even when they experience complications. Similar finding also depicted that participants were not satisfied with the services that they were offered by night staff and they indicated that they regretted their choice of health facility and the services that were

offered made them feel very insignificant. This can affect their attitude towards health facility deliveries and contributes to future delays in seeking help.

Maltreatment of women in childbirth has been documented in many studies whereby provider power dominance was identified in the midwifery-woman relations during childbirth. Midwives perceive themselves to be superior to women in labour and may practice any form of punishment to achieve power control and therefore the women feel they have to be submissive to any form of mistreatment (Jewkes and Penn-Kekana, 2015:1). This was also apparent in the study's findings where a participant mentioned that the providers have the right to scold her because it was her first time to deliver and therefore midwives are entitled to do whatever they want to do as long as they help her deliver. Adatara *et al.* (2019:4) agree with the findings and verify that sometimes women do not express their feelings of perceived mistreatment as they fear confronting healthcare workers about poor services because they feel vulnerable.

The way providers communicated with the women was also expressed as part of the provider attitude; some participants described the positive provider attitude based on their communication. Participants highlighted that the way providers communicated with them made them feel comfortable and in safe hands whereby they were able to discuss their problems with provider.

In conclusion the findings revealed experiences of good and bad provider attitude where most women reported that the night shift staff had bad attitudes and day shift staff were regarded as more friendly and had good communication skills. Bishanga *et al.* (2019:11) noted that even in facilities with more equipment, better infrastructure and highly skilled staff, women still reported disrespectful care which could be due to fatigue from high woman flow. Therefore, results reveal a gap in the attitude of healthcare providers who were on night shift which could be influenced by other factors such as high woman flow or a shortage of staff.

5.2.4 Women's childbirth needs

The theory of discrepancy states that satisfaction is determined by the difference between a woman's expectations and the services that were actually provided (Sawyer *et al.*, 2013:1). It is important to identify women' needs as they determine their expectations so that their needs will be incorporated into the care. Promptness of care, cleanliness, good physical environment, privacy and good interpersonal behaviour were identified as some of the women's needs that influence satisfaction about services rendered in childbirth (Srivastava, Avan, Rajbangshi and Bhattacharyya, 2015:6). Promptness in care was identified as a critical factor for participants'

satisfaction with regard to childbirth care, which involved the waiting time before care is given, timely decision making and timely referral to the next level of care (Srivastava *et al.,* 2015:6). Findings revealed participants' satisfaction when they were attended to on time and when appropriate decisions were made in a timely manner. One participant showed that she was attended to immediately on arrival in the maternity ward when she presented signs of labour and the doctors were called immediately when the midwives discovered that the baby was not in a normal position. The doctors also came in time and she was taken for a caesarian section immediately.

On the other hand, some participants had the opinion that they were denied timely services such that complications could have occurred even though they were at the hospital. In a met-synthesis that explored experiences of women with severe maternal mobility, findings showed that women's dissatisfaction was mostly due to delay in assessment, delay in taking appropriate decisions and delay in making appropriate diagnosis (Norhayati, Surianti and Hazlina, 2015:6). Similarly, the findings proved the occurrence of complications during childbirth due to delays in making the right diagnosis. One participant believed that had it been that there were other midwives or doctors her child could have been born without injury, as there was a delay in making the right diagnosis and hence the delay of the appropriate management.

Jha, Larsson, Christenson and Svanberg (2017:2) indicate that one of the women's needs in childbirth is to be involved in decision making about their care. Some participants reported that they were informed about aspects of their care that included the benefits and disadvantages of certain procedures or actions. They felt empowered as they understood the reasoning behind the care that they were offered. When interventions are required during childbirth women need to be involved in active decision making so that they feel a sense of empowerment and accomplishment (Down *et al*., 2018:2).

Maintenance of good hygiene, cleanliness and good housekeeping had an impact on the way women perceived childbirth services (Srivastava *et al.,* 2015:6). Findings revealed in-conducive environment due to poor hygiene, dirty linen and messy environment. Participants noted that the environment was dirty to a point where they were unable to pour drinking water from the taps as there was blood on the sink.

Human resource availability has a direct impact on the quality of healthcare service provision; the staffing norms for Lesotho Ministry of Health are dependent on the establishment's list which has

a fixed range and does not take it to account the demand for services (Lesotho public health sector expenditure review, 2017:21). Participants raised concerns about the number of midwives who provide childbirth services at night as a shortage of providers can lead to complications.

Literature indicates that in low-income countries there is a shortage of staff in maternity units mostly at night when the demand is high, and these results in women preferring home birth versus facility deliveries (N'Gbichi *et al.*, 2019:1). One participant mentioned that they were about ten women in labour and were assisted by one midwife and she became worried with the ratio of one midwife to the number of women in labour. She was thinking about what would happen in the case of multiple women requiring assistance at the same time. She further mentioned that this can lead to cases where women deliver on their own without midwives' assistance but while at the health facility.

The WHO quality statements on standards for improving quality maternal and neonatal care indicate that in order to achieve quality care, maternity staff should be skilled, competent and be present 24 hours in sufficient number for the expected workload (WHO, 2016:23). In Lesotho the number of established positions in government hospitals is variable and a staffing pattern is not based on bed occupancy or demand (Lesotho public health sector expenditure review, 2017:21).

In brief participants' needs for a satisfactory childbirth experience were not met, factors such as delays in provision of care were more prominent than immediate care, and moreover there were more reports of uninformed care and dehumanisation of childbirth where women were treated as objects with no explanation of care and the results after examination. What was more apparent to participants was the shortage of staff especially at night, and with no resources and poor hygiene in both hospitals.

5.3 LIMITATIONS OF THE STUDY

The study was of a qualitative approach; therefore, study findings cannot be generalised to the entire population. The study was done in two public hospitals in the urban and sub-urban regions. Private hospitals and public hospitals in the rural, hard to reach area, were not included in the study of which may have different childbirth experiences**.**

5.4 RECOMMENDATIONS

Table 5.1: List of recommendation and sub points

RECOMEWNDATIONS	SUBPOINTS
5.4.1.Staff motivation	• Acknowledgement of good performance • Financial incentives
5.4.2.Strengthened support for women in labour	• Use of doula • Family support
5.4.3.Conducive working environment	• Cleanliness • Availability of material resources • Improved staffing strategies

5.4.1 Staff motivation

Demotivation of nurses and midwives was found to be a significant stumbling block in the provision of quality maternal services in sub-Saharan Africa, therefore literature suggests a combination of intrinsic and extrinsic factors to improve staff performance (Aninanya *et al.*, 2016:2) .The study's findings revealed a difference in the perception of care in most factors which influence experience of care. Some participants reported satisfaction while other participants experienced dissatisfaction, some reported positive provider attitude others negative attitude. The contradictory findings of women's experiences may be related to staff demotivation and disempowerment.

5.4.1.1 Acknowledgment of good staff performance

The participants mentioned that providers were not the same; some were friendly while others were cruel. Some personnel were intrinsically motivated as they engaged in activities that lead to personal satisfaction and which thereby lead to improved performance and a sense of achievement (Aninanya *et al.,* 2016:2). The Healthcare workers who perform well and provide quality services to women should be acknowledged so that they feel appreciated and this will motivate them to maintain the good performance.

Jewkes and Penn-Kekana (2015:1) mentioned that in some other instances, healthcare workers who mistreat women in labour feel disempowered as they work under stressful situations or in an unconducive environment or may be experiencing abuse in their own personal lives. Recognition of good performance would also help less performing healthcare providers to improve their services.

5.4.1.2 Financial incentives

Furthermore forms of extrinsic motivation may also be used such as verbal recognition and or financial rewards to positively influence healthcare providers to value their work (Aninanya *et al.,* 2016:2). Performance based financing (PBF) was introduced by the WHO as a strategy to

motivate providers to meet targeted indicators based on their performance (Olufunke, Online: 2017). The initiative helped to motivate staff so that they would provide good quality services. Even though the initiative depended on donor funding with a specified duration and are not long-term, the hospitals could develop smaller scale funding with similar intentions. Moreover, participants who were satisfied with services mentioned that financial incentives can motivate staff to continue providing good services.

5.4.2 Strengthened support for women in labour

Literature has revealed that midwives alone cannot give the maximal support to women in labour, as the kind of support that women require like constant physical presence may not be possible due to the workload and other work responsibilities (Lunda *et al.*, 2018:4).

5.4.2.1 Use of doula

In several countries doula support has yielded positive results in the provision of appropriate companionship for women during childbirth. It is recommended that Lesotho public hospitals engage volunteers as a support structure for childbirth.

5.4.2.2 Family support

A further recommendation is that the public hospitals should allow women to have their relatives as support where possible as this has been found to positively affect the childbirth outcome. Even though literature has highlighted that infrastructure plays a role in the involvement of family member as support during labour, the benefits thereof are very important. Healthcare provider attitude plays a role in the facilitation of family support as circumstances are not constant or the same. In some hospital with low women flow family support is possible. It is therefore recommended that where circumstances allow, women be given the chance to have a companion of their choice for a fulfilling birth experience.

5.4.3 Conducive working environment

A conducive work environment motivates staff to perform well as they feel supported and have access to the necessary resources to do their work efficiently. Findings have identified factors that hamper a conducive environment in public hospitals for healthcare providers to provide quality service. Limited material resources and a shortage of staff were identified as the main factors to consider in the reconstruction of quality service provision to improve maternal and newborn outcomes.

5.4.3.1 Cleanliness

Findings have shown reports of poor hygiene in the maternity ward, where there are vulnerable groups with lowered immunity. There is a need to strengthen the infection control as poor hygiene can affect the health of mothers and their babies, even after discharge from the hospital. There should be a health care provider responsible of infection control in maternity so that standards are set, monitored and adhered to. Fraser *et al*. (2010:917) mention that a safe environment is critical, especially in hospitals, as babies are at risk of cross infection due to lowered immunity.

5.4.3.2 Availability of material resources

The study findings have proved that availability of resources and equipment helps in good monitoring and management of complications during childbirth. Use of appropriate equipment helps providers to make an early diagnosis and therefore ensure the proper management of women in labour. Srivastava *et al.* (2015:6) emphasise that resources should be given a priority as they influence women's satisfaction and utilisation of healthcare facilities. It is therefore recommended that the hospitals prioritise the procurement of essential equipment and material resources that are critical in the provision of quality care as stated by the WHO recommendation: Intrapartum care for a positive childbirth experience.

5.4.3.3 Improved staffing strategies

Srivastava *et al.,* (2015:6) emphasise the importance of adequate staffing in maternity as it is linked to the quality of service provision and women's satisfaction. Similarly, the findings of the study have shown that most of the time dissatisfaction of participants was associated with a shortage of staff where providers had bad attitudes and delayed in offering services to the women. In public hospitals in Lesotho, Midwives' ratio to the population is 10.2 per 10,000, which was identified to be below the recommended standards by the World Health Organisation (Lesotho public health sector expenditure review, 2017:23).

For the country to fully combat high maternal deaths there should be implementation strategies at hand to increase the number of staff working in maternity and in maternal and child health. Staffing should be based on bed occupancy and demand in order to give priority maternity and emergency departments as they are unpredictable. Furthermore, public hospitals should allow other forms of companionship during childbirth to easy the workload off midwives so that they can concentrate more on technical aspect of care.

The public health sector expenditure review has also mentioned that there is a need to review the establishment list as the staffing strategies are not based on workload or bed occupancy and this affects the quality of care provided in public facilities (Lesotho public health sector expenditure review, 2017:21). The public hospital may establish a staffing pattern in relation to average delivery rates per month. Participants mentioned that in comparison they noted that there were more health care providers during the day than at night. Findings have shown that when the number of personnel is increased quality of the services may be more appealing to women.

5.5 FUTURE RESEARCH

A qualitative study to describe factors that hamper quality service provision during childbirth should be undertaken, as the information can explain the midwives' experiences on the factors that lead to the unmet needs of women during childbirth.

5.6 DISSEMINATION

The study will be accessible on the Stellenbosch University website. Moreover, the researcher will share the findings with the Lesotho Ministry of Health and the findings will be presented to managers of the participating hospitals. Articles will be published in peer-reviewed journals.

5.7 CONCLUSION

The study findings revealed poor support for women during childbirth. The ratio of midwives to women, especially during the night shift, was not acceptable and believed to contribute to occurrences of labour complications. Furthermore, there were delays in attendance to women on admission and delays in decision making. There is a strong association between delays and the shortage of providers which may result in neglect of women during childbirth. Poor hygiene and shortage of equipment affected the provision of quality care and how women experienced their care.

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APPENDICES

Appendix 1: Semi structured interview guide

Section A

Demographic information

Age:

Marital status:

Parity:

Level of education:

Section B

Interview questions

1. Could you please tell me about your childbirth experiences in a public hospital?

Probing question

- In general how did you feel about the healthcare services you received during childbirth?
- Were you satisfied with the care you received? Why did you feel so?
- Can you think of ways in which childbirth service quality could be enhanced in Lesotho public hospitals?

2. How did you feel about healthcare facility services you have received?

3. How was support during your childbirth?

Probing question

- Which childbirth events do you feel like you received most support with? What about those where you received less support?
- In your opinion, which aspects of childbirth need more support?

4. Can you describe your experience and relationship with your healthcare provider?

Probing question

- Can you tell me about your health care provider' attitudes during birth events? How did those attitudes make you feel?
- What do you think can be done to enhance birth attendants' attitudes during child birth?

5. Were your childbirth needs met?

Appendix 2: Participant information leaflet and consent form

TITLE OF RESEARCH PROJECT: Women's childbirth experiences in two public hospitals in Lesotho.

DETAILS OF PRINCIPAL INVESTIGATOR (PI)

First name and surname: Malintle Motaba

Full postal address: Box 29 Roma 0180 Maseru Lesotho

PI Contact number: +26658001460

Ethics reference number: 9283

HEA-2019-9283

You are invited to take part in a research project to explore women's childbirth experiences in two public hospitals in Lesotho.

- Please take some time to read the information presented here, which will explain the details of this project.
- Please ask the study staff any questions about any part of this project that you do not fully understand.
- It is important that you are completely satisfied and that you clearly understand what this research entails and how you could be involved.
- Also, your participation is entirely voluntary and you are free to decline to participate. In other words, you may choose to take part, or you may choose not to take part and you are assured never to be a victim in any way. Refusal to participate will involve no penalty or loss of benefits or reduction in the level of care to which you are entitled to.
- You are free to withdraw from the study at any point.

This study has been approved by the Health Research Ethics Committee at Stellenbosch University. The study will be conducted according to the ethical guidelines and principles of the international Declaration of Helsinki. The South African Guidelines for Good Clinical Practice (2006), The Medical Research Council (MRC) Ethical Guidelines for Research: Principles Processes and Studies (2015).The study will also follow the guiding principles of health research in Lesotho.

What is this research study all about?

The study is aimed at exploring women's childbirth experiences in two public hospitals in Lesotho so that services can be improved.

The study will be conducted in two public hospitals. A total of sixteen participants will be interviewed; eight from each hospital or till data saturation is reached. The population will be women who have delivered in public hospital and will be attending six weeks post natal care clinic at the participating hospitals.

Data will be collected using semi structured interview guide with individual participants.

The interviews will be conducted in Sesotho or English depending on your preference.

A digital audio tape recorder will be used to record the interview session which is anticipated to last for 40 to 60 minutes.

How will the study participants be chosen?

A sample will be chosen from the total population by means of purposive sampling. Participants who are willing to participate will be selected based on inclusion criteria.

Why do we invite you to participate?

We invite you to participate because you have attended a six week post natal clinic and also because you have given birth in the participating public hospital and would like to know your childbirth experiences.

Will you benefit from taking part in this research?

There are no personal benefits from the study, but if you participate the information you give will be used to improve the childbirth services in these public hospitals.

Are there any risks involved in your taking part in this research?

- There is an anticipated risk of emotional distress, which may come as result of the interview. However, such participants will be referred for counseling services, which will be arranged prior to the interview**.**

Who will have access to the information?

The information will be accessed by the researcher and supervisor only. The information collected will be protected and treated as confidential. Real names of the hospitals and participants will not be used when writing the thesis or when publishing the study results. The audio tapes will be stored in a password protected device.

Will you be paid to take part in this study?

You will not be paid to take part in the study. But transport reimbursement will be given to participants who stay very far from the hospital for their time inconvenience.

Is there anything else that you should know or do?

- If you have any concerns or complaints that were not adequately addressed by the study researcher, you can contact the Health Research Ethics Committee at +277 219389207
- You will receive a copy of this information and consent form for your own records.

Declaration by participant

By signing below, I …….…… agree to take part in a research study entitled women's childbirth experiences in two public hospital in Lesotho.

I declare that:

- I have read this information and consent form, or it was read to me, and it is written in a language in which I am fluent and comfortable with.

- I have had a chance to ask questions and I am satisfied that all my questions have been answered.

- I understand that taking part in this study is voluntary, and that I have not been pressurized to take part.

- I may choose to leave the study at any time and nothing bad will come of it, and I will not be penalized or prejudiced in any way.

Signed at (place) .....……. on (date) ……..…….. 2019.

Signature of participant…….

Signature of witness……..

Declaration by investigator

I Malintle Motaba declare that:

- I explained the information in this document in a simple and clear manner to ……..
- I encouraged him/her to ask questions
- I am satisfied that she completely understands all aspects of the research, as discussed above.

Signed at (place) .....…..…….. on (date) ……...…….. 2019.

Signature of investigator…….

Signature of witness…….

Appendix 3: Stellenbosch ethical approval with stipulations

UNIVERSITEIT STELLENBOSCH UNIVERSITY

Approved with Stipulations

New Application

15/07/2019

Project ID: 9283

HREC Reference No: S19/03/065

Project Title: Women's childbirth experiences in public hospital in Lesotho

Dear Mrs Malintle Motaba

The **New Application** received on 04/07/2019 08:58 was reviewed by members of the **Health Research Ethics Committee** via Minimal Risk Review procedures on 15/07/2019 and was approved with stipulations.

Please note the following information about your approved research protocol:

Protocol Approval Period: **15 Jul 2019 - 14 Jul 2020**

The stipulations of your ethics approval are as follows:

- Edits were made to the protocol, but there are still language mistakes in the protocol, SOP and ICF that requires further editing
- Recruitment: The agreement signed by the participants for referral should be a separate document from the SOP and should include the study title
- Include the full ethics reference number in the ICF: HEA-2019-9283

Please remember to use your project ID (9283) and ethics reference number (S19/03/065) on any documents or correspondence with the HREC/UREC concerning your research protocol.

Translation of the consent document(s) to the language(s) applicable to your study participants should now be submitted to the HREC.

Please note that this decision will be ratified at the next HREC full committee meeting. HREC reserves the right to suspend approval and to request changes or clarifications from applicants. The coordinator will notify the applicant (and if applicable, the supervisor) of the changes or suspension within 1 day of receiving the notice of suspension from HREC. HREC has the prerogative and authority to ask further questions, seek additional information, require further modifications, or monitor the conduct of your research and the consent process.

After Ethical Review:

Please note you can submit your progress report through the online ethics application process, available at: https://apply.ethics.sun.ac.za and the application should be submitted to the Committee before the year has expired. Please see Forms and Instructions on our HREC website for guidance on how to submit a progress report.

The Committee will then consider the continuation of the project for a further year (if necessary). Annually a number of projects may be selected randomly for an external audit.

Provincial and City of Cape Town Approval

Please note that for research at a primary or secondary healthcare facility, permission must still be obtained from the relevant authorities (Western Cape Department of Health and/or City Health) to conduct the research as stated in the protocol. Please consult the Western Cape Government website for access to the online Health Research Approval Process, see: https://www.westerncape.gov.za/general-publication/health-research-approval-process. Research that will be conducted at any tertiary academic institution requires approval from the relevant hospital manager. Ethics approval is required BEFORE approval can be obtained from these health authorities.

We wish you the best as you conduct your research.

For standard HREC forms and instructions, please visit: Forms and Instructions on our HREC website (www.sun.ac.za/healthresearchethics)

If you have any questions or need further assistance, please contact the HREC office at 021 938 9677.

Yours sincerely,

Ms Elvira Rohland
Health Research Ethics Committee 2 (HREC2)

National Health Research Ethics Council (NHREC) Registration Number:

REC-130408-012 (HREC1)•REC-230208-010 (HREC2)

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Appendix 4: Ethical approval to amendment

UNIVERSITEIT
STELLENBOSCH
UNIVERSITY

Approval Letter
Amendment

05/08/2019

Project ID: 9283

Ethics Reference No: S19/03/065

Title: Women's childbirth experiences in two public hospitals in Lesotho

Dear Mrs Malintle Motaba,

Your amendment request dated 19 July 2019 refers.

The Health Research Ethics Committee (HREC) reviewed and approved the amended documentation through an expedited review process.

The following amendment was reviewed and approved:

1. Change of the study title.

Where to submit any documentation

Kindly note that the HREC uses an electronic ethics review management system, *Infonetica*, to manage ethics applications and ethics review process. To submit any documentation to HREC, please click on the following link: https://applyethics.sun.ac.za.

Please remember to use your Project ID **[9283]** and ethics reference number **[S19/03/065]** on any documents or correspondence with the HREC concerning your research protocol.

Yours sincerely,

Mr. Francis Masiye,

HREC Coordinator,

Health Research Ethics Committee 2 (HREC2).

National Health Research Ethics Council (NHREC) Registration Number:

REC-130408-012 (HREC1)•REC-230208-010 (HREC2)

Federal Wide Assurance Number: 00001372
Office of Human Research Protections (OHRP) Institutional Review Board (IRB) Number:
IRB0005240 (HREC1)•IRB0005239 (HREC2)

The Health Research Ethics Committee (HREC) complies with the SA National Health Act No. 61 of 2003 as it pertains to health research. The HREC abides by the ethical norms and principles for research, established by the World Medical Association (2013). Declaration of Helsinki: Ethical Principles for Medical Research Involving Human Subjects;the South African *Department of Health (2006). Guidelines for Good Practice in the Conduct of Clinical Trials with Human Participants in South Africa (2nd edition)*; as well as the Department of Health (2015). Ethics in Health Research: Principles, Processes and Structures (2nd edition).

The Health Research Ethics Committee reviews research involving human subjects conducted or supported by the Department of Health and Human Services, or other federal departments or agencies that apply the Federal Policy for the Protection of Human Subjects to such research (United States Code of Federal Regulations Title 45 Part 46); and/or clinical investigations regulated by the Food and Drug Administration (FDA) of the Department of Health and Human Services.

Page 1 of 1

Appendix 5: Letter requesting permission from hospital A

Letter requesting permission to conduct an academic research

Date: 30/07/2019

To: District Health Manager (DHMT) [redacted]

RE: PERMISSION TO CONDUCT A HEALTH RELATED ACADEMIC RESEARCH

TOPIC: Women's childbirth experience in two public hospitals in Lesotho

Dear sir /Madam

I hereby request to conduct health related academic research in our institution as per the above mentioned tittle. I am a second year student, studying masters in nursing science in the faculty of heath science from Stellenbosch University.

Attached to this application kindly find

- Ethical approval letter from Stellenbosch University ethics and clearance committee
- Ethical approval letter from Lesotho ethics clearance committee (Ministry of health)

I hope my application shall have your outmost attention

Yours sincerely

Malintle Motaba

Student number: 22072047 Ethics reference number: 9283

Contact number: +26658001460 Email address: rosemotaba@gmail.com

Appendix 6 letter requesting permission from Hospital B

Letter requesting permission to conduct an academic research

Date: 22/07/2019

To: District Medical Officer (DMO) [redacted] government Hospital

RE: PERMISSION TO CONDUCT A HEALTH RELATED ACADEMIC RESEARCH

TOPIC: Women's childbirth experience in two public hospitals in Lesotho

Dear sir /Madam

I hereby request to conduct health related academic research in our institution as per the above mentioned tittle. I am a second year student, studying masters in nursing science in the faculty of heath science from Stellenbosch University.

Attached to this application kindly find

- Ethical approval letter from Stellenbosch University ethics and clearance committee
- Ethical approval letter from Lesotho ethics clearance committee (Ministry of health)

I hope my application shall have your outmost attention

Yours sincerely

Malintle Motaba

Student number: 22072047 Ethics reference number: 9283

Contact number: +26658001460 Email address: rosemotaba@gmail.com

Appendix 7 Approval letter from Lesotho ethics committee

LESOTHO

Ministry of Health
PO Box 514
Maseru 100

REF: ID129--2019

Date: 08 April 2019

To
Malintle Motaba
Student # 2207 2047
University of Stellenbosch

Category of Review:
[X] Initial Review
[ ] Continuing Annual Review
[ ] Amendment/Modification
[ ] Reactivation
[ ] Serious Adverse Event
[ ] Other _____

Dear M. Motaba,

RE: Women's childbirth experience in public hospital in Lesotho

This is to inform you that the Ministry of Health Research and Ethics Committee, after reviewing your proposal **APPROVED** the proposal and hereby authorizes you to continue the study according to the activities and population specified in the protocol. Departure from the approved protocol will constitute a breach of this permission.

This approval includes review of the following attachments:
[x] Protocol version: Dated March 18, 2019
[ ] Need Assessment Questionnaire in English
[ ] Sesotho consent forms
[x] Data collection form: Semi-structured interview guide in English & Sesotho
[ ] Participant materials
[x] Other materials: CV of the PI

This approval is **VALID** until 07 April, 2020.

Please note that an annual report and request for renewal, if applicable, must be submitted at least 6 weeks before the expiry date.

All serious adverse events associated with this study must be reported promptly to the MOH Research and Ethics Committee. Any modifications to the approved protocol or consent forms must be submitted to the committee prior to implementation of any changes.

We look forward to receiving your progress reports and a final report at the end of the study. If you have any questions, please contact the Research and Ethics Committee at rcumoh@gmail.com (or) 22226317.

Sincerely,

Dr. Nyane Letsie
Director General Health Services

Dr. Llang Maama
Member of the NH-IRB

Appendix 8: Approval letter from hospital A

[redacted]

Box [redacted]

[redacted]

15/ August/2019

Student Number: 22072047

Ethics reference No: 9283

Stellenbosch University

Dear Mrs. Malintle Motaba

RE: PERMISSION TO CONDUCT AN ACADEMIC REASERCH

With reference to your letter dated 30/07/2019 requesting permission to conduct academic research titled: Women's childbirth experiences in two public hospitals in Lesotho. I here in inform you that permission has been granted to do the academic research.

You will be given needed support and assistance whenever is required. We will appreciate to be given report on the findings in order to strengthen our childbirth services

Yours sincerely

[redacted] ing Services

Appendix 9: Approval letter from hospital B

[redacted] Government Hospital

P. Box [redacted]

[redacted]

12th August 2019

MALINTLE MOTABA

Student # 2207 2047

University of Stellenbosch

Dear Madam,

Re: Permission to conduct a health related academic research

Reference is made to your letter dated 22/07/2019 in which requested permission to conduct academic research study on **"women's childbirth experience in two public hospital in Lesotho"**

I am pleased to inform you that permission has been granted to conduct above mentioned study in this facility. The hospital is willing to accord necessary support that you may require and would appreciate it if you can share final report of the study for betterment of services.

I wish you peaceful stay in our facility and wish you best of luck in this sometimes strenuous process.

Yours Sincerely

[redacted]

Manager Hospital Nursing Services

[redacted]

MANAGER HOSPITAL NURSING SERVICES

[redacted]

Appendix 10: Declaration from language editor

Barbara Dupont Language School

37A Hilltop Road
Hillcrest
3610
Cell No: 0846668351

1st December 2019

To Whom It May Concern

EDITING OF ACADEMIC THESIS

I hereby confirm that I, Barbara Dupont, edited the thesis written by Malintle Motaba titled "Women's Childbirth Experiences in Two Public Hospitals in Lesotho" and commented on the grammatical anomalies in MS Word Track Changes and review mode by the insertion of comment balloons prior to returning the document to the authors. Corrections were made in respect of grammar, punctuation, spelling, syntax, tense and language usage as well as to sense and flow. Reference guidelines and additional comments were provided to assist with corrections.

I have a been teaching English for the past 12 years and have a Cambridge CELTA diploma in teaching English as a foreign language. I am also employed by the British Council as an official IELTS examiner for Southern Africa. I have been editing academic and other documents for the past four years, regularly editing the research dissertations, articles and theses of the School of Nursing, Environmental Studies and various other schools and disciplines at the University of KwaZulu-Natal and other institutions, as well as editing for publishing firms and private individuals on a contract basis.

I trust that this document will prove acceptable in terms of editing criteria.

Yours faithfully

B Dupont

Barbara Dupont

Appendix 12: Declaration by Technical editor

Lize.net
COMMUNICATION (Pty) Ltd
Company registration: 2019/050723/07

3 December 2019

To whom it may concern

This letter serves as confirmation that I, Lize Vorster, performed the language editing and technical formatting of Malintle Motaba's thesis entitled:

Women's childbirth experiences in two public hospitals in Lesotho.

Technical formatting entails complying with the Stellenbosch University's technical requirements for theses and dissertations, as presented in the Calendar Part 1 – General or where relevant, the requirements of the department.

Yours sincerely

Lize Vorster
Language Practitioner

Vygie street 9, Welgevonden Estate, Stellenbosch, 7600 * e-mail: lizevorster@gmail.com * cell: 082 856 8221